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SPACE FOR THE MENTALLY RETARDED IN SOUTH DAKOTA. FINAL REPORT.

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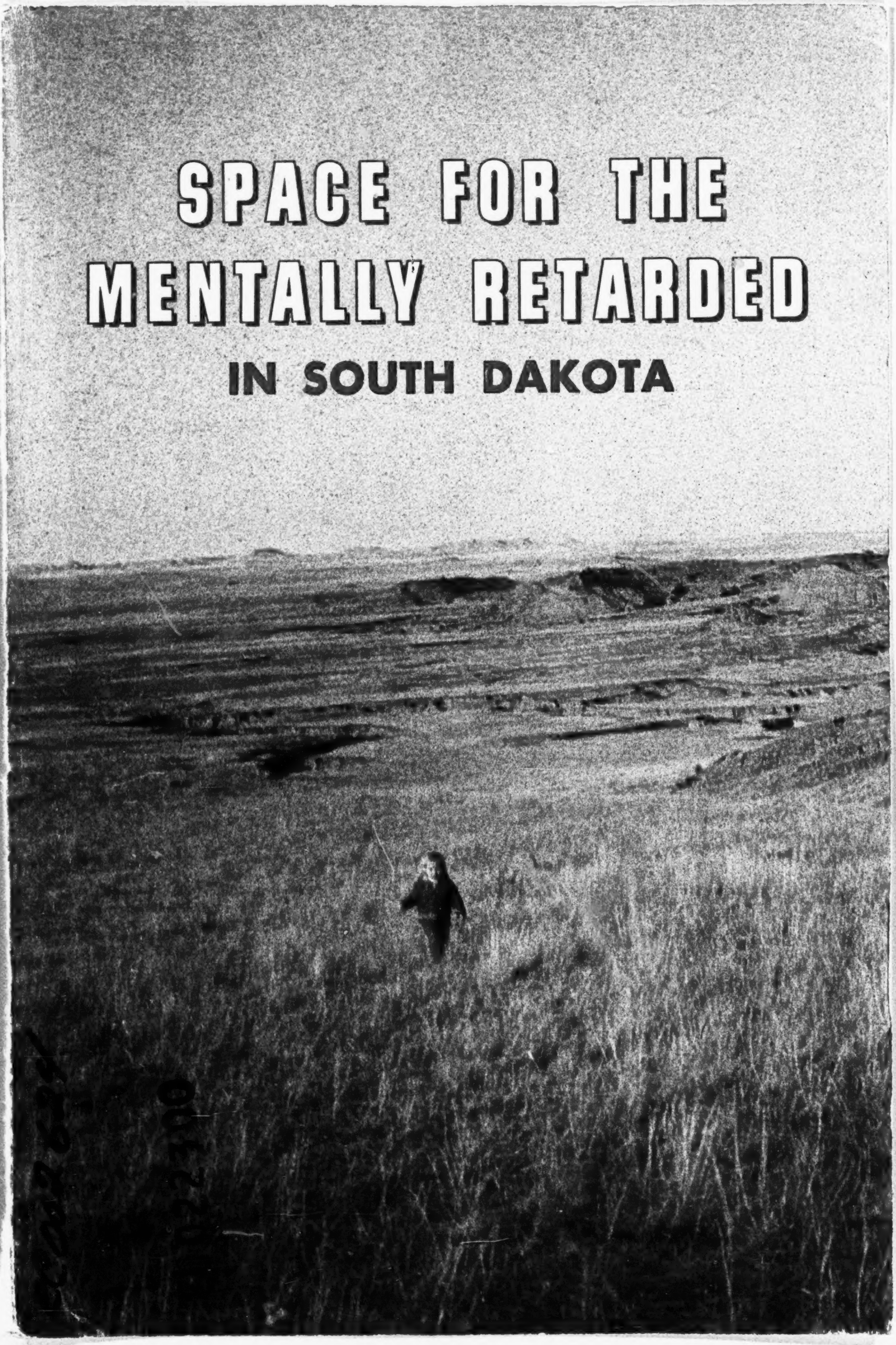
The 10 priority recommendations for aiding the mentally retarded in South Dakota are presented. Summaries are provided of recommendations for federal and state legislative action and for state agencies, communities, state medical and hospital associations, and private organizations. The State and the method of planning are discussed; mental retardation is defined; and an administrative report is given. Committee reports are included on the following: public health and prenatal care; private medical practice; early diagnosis, treatment, and evaluation; family counseling and assistance; day care; education and training; vocational rehabilitation, occupation, and employment; social development, recreation, and religion; guardianship, and legal protection and processes; geriatrics; dependent living; public and professional information; research and statistics; personnel and manpower; and prevention. The appendix contains a copy of the county questionnaire, a glossary, and lists of the members of the coordinating and state committees, of regional and county chairmen, and of the planning staff. (AP)

SPACE FOR THE MENTALLY RETARDED

IN SOUTH DAKOTA



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SPACE FOR THE MENTALLY RETARDED

IN SOUTH DAKOTA

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FINAL REPORT AND RECOMMENDATIONS OF SOUTH
DAKOTA COMPREHENSIVE PLANNING FOR
MENTAL RETARDATION

ED022300

Acknowledgments

This project was supported in part by a Mental Retardation Planning Grant awarded by the Public Health Service, Department of Health, Education, and Welfare.

The State Department of Health, Mental Retardation Planning Office, gratefully acknowledges the participation of the South Dakota Association for Retarded Children, without whose complete cooperation this project could not have become a reality.

December 31, 1965

To: The Honorable Nils A. Boe
Governor of South Dakota
Pierre, South Dakota
and
Members of the South Dakota Legislature.

It is an honor to present to you the attached report and recommendations of the South Dakota Comprehensive Planning for Mental Retardation. The material submitted is the result of the thoughts and efforts of eighteen months' duration on the part of four thousand citizens of South Dakota who have seen fit to assist in this project in behalf of the mentally retarded.

This booklet contains factual information gathered by committees through personal contact, questionnaires, and public meetings. The material was evaluated by committees whose membership consisted of both professional and lay persons.

The recommendations made call for action at various levels, i.e. federal, state legislative, state agencies, local communities, special and private organizations.

It is recognized that the implementation of the recommendations will require, in some instances, considerable time and a concerted effort by many individuals. None-the-less, it is an effort which is urgent and essential to the 18,000 mentally retarded persons in South Dakota and the thousands more affected by their opportunities to be accepted members of society.

Sincerely yours,

Keith I. Newcomb, Director
Mental Retardation Planning

UNITED STATES SENATE
Washington, D. C.

Dear Fellow Citizens of South Dakota:

Last fall it was my privilege and responsibility to serve as Honorary Fund Drive Chairman of the South Dakota Association for Retarded Children. Serving in that capacity I had an intimate opportunity for the first time to become acquainted both with the problems and the opportunities confronting those in our State who are mentally retarded or who suffer from one type of brain damage or another. As a consequence, I have been tremendously impressed by the progress which can be made and the potentiality and improvement which can be attained through careful planning, adequate staffing, and scientific guidance of both work and study projects adapted to the learning levels of those who are mentally retarded.

While certain communities are moving forward energetically and constructively to open up these opportunities for the mentally retarded, it is likewise true that for some families and some communities very little is being done to make available the care and the constructive programs essential to improving opportunities for mentally retarded people and for helping them to find a niche in our society where they can serve both constructively and happily.

It is my hope that a program for expanding the training, care and opportunities for the mentally retarded can move forward effectively in South Dakota.

Cordially yours,

Karl E. Mundt
United States Senator

UNITED STATES SENATE
Washington, D. C.

Dear Fellow Citizens:

As one who has long been deeply concerned about mental retardation, I regard "Space for the Mentally Retarded" as a significant step forward by our State of South Dakota.

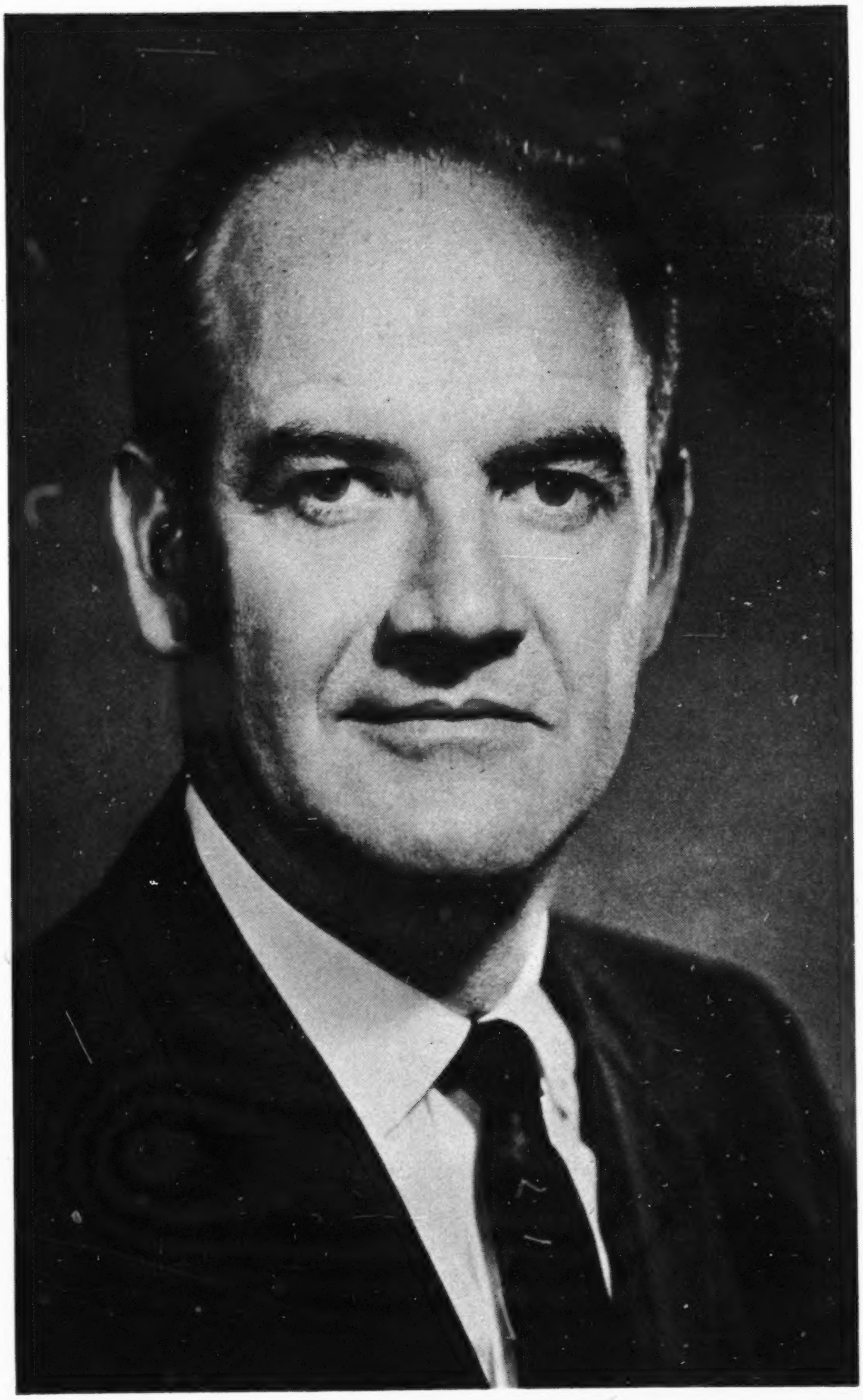
We have, as this state plan indicates, a long way to go in developing better services for the mentally retarded. We have neglected them for far too long.

However, I am confident that we **can** provide excellent care and rehabilitation for the mentally retarded. We **can,** by working together, live up to our long-established standards of compassion and dignity. We **can** help to lead the mentally retarded out of the darkness and into the light.

It is my earnest hope that all of my fellow South Dakotans will do everything they can to support the excellent recommendations contained in this mental retardation state plan. If individuals, members of the medical profession, and local communities join together in an effort to solve the enormous problem of mental retardation, we as South Dakotans will have much to be proud of.

Sincerely,

George McGovern
United States Senator



EXECUTIVE PLANNING COMMITTEE

Chairman: Ben Hins, Director, Vocational Rehabilitation, Pierre

Robert Kelley, Attorney at Law, Lemmon

Charles Snow, S. Dak. Ass'n. for Retarded Children, Mitchell

E. H. Heinrichs, M.D., Pediatrician, Watertown

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John Madigan, Supervisor, Office of Special Education, Pierre

Howard Chinn, Supt., Redfield State Hospital and School, Redfield

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Priority Recommendations Requiring South Dakota's Attention for the Mentally Retarded

Ten major concerns are listed here which need action by South Dakota citizens in order to improve conditions of treatment and assure just handling of the mentally retarded in keeping with modern day knowledge.

1. Public education to the fact that mental retardation is a condition of retarded intellectual development from which 85% can be recovered to gain a large degree of independence. (An extended planning and implementation project is planned to establish local information and referral points in communities, and will assist in public education.)
2. Diagnostic service should be available in South Dakota to insure the earliest possible complete evaluation and planning for the proper handling of conditions of mental retardation.
3. Improved institutional services at Redfield State Hospital and School. (Increased staff is needed at both Redfield and Custer, and an Activities building is essential.)
4. Expanded Vocational Rehabilitation services. (Increased appropriations are necessary in order to meet the growing number of persons known to need services.)
5. Training in sheltered workshops should be subsidized by the State, and made available to those retarded persons who need such a facility. (Residential facilities are needed in order to serve persons who live outside the cities where workshops are located.)
6. Residential educational centers are needed to serve those retarded children who live too far from the special education classrooms to travel daily.
7. Counseling as a public service should be made available to parents of retarded children on a broad scale even before the child reaches school age.
8. Special education classes are needed in all schools having an enrollment of 200 or over who do not have classes for the retarded at the present time.
9. Recruitment of persons trained in professions to serve the retarded and training for persons to become professional workers who will stay in South Dakota must be increased.
10. A coordinating agency should be established, responsible for encouraging proper programming for the retarded through other state agencies and encouraging cooperation with voluntary organizations in assisting in the best use of services.

Summary of Recommendations for Federal Action

It is recommended that:

1. Comprehensive planning for mental retardation should be continued.

2. Complete reevaluation of the circumstances surrounding the Indian population should be undertaken.

3. Publicity should be given to the availability of employment for retarded persons through the Civil Service Commission.

4. The exemption from examination for Civil Service positions for retarded persons should be extended and made a permanent program.

5. Additional Employment Security counselors should be made available in South Dakota to assist in the employment placement of retarded persons.

6. A committee should be established on a regional basis to evaluate new information and changing views in mental retardation relating to diagnosis, treatment, and prevention, and to distribute its findings to professional persons.

Summary of Recommendations for State Legislative Action

It is recommended that:

1. An appropriation of $15,000 should be made to establish a cytogenetic laboratory service at the Medical School at the University of South Dakota.
2. A diagnostic service should be established so that those needing the best available professional information and services may have some place to obtain this service in one location without undue financial hardship. (Location of the diagnostic service is of very little concern, as long as it can be established soon somewhere within the state and be reliable. It is not essential that treatment be available in the same location. Federal assistance is available to establish both a central unit and sub-units which could provide some services in regions nearer to the population. Such a diagnostic service would benefit other persons as well as the retarded.)
3. An appropriation of $650,000 should be made for the construction of an Activities Building at Redfield State Hospital and School. (The proposed facility would house services and provide space to help the institution to prepare patients for community living.)
4. A supplemental appropriation should be made to the Division of Vocational Rehabilitation in order to expand the services to serve an increased case load.
5. An appropriation should be made to assist in the cost of operation of the Adjustment Training Centers (sheltered workshops) serving the mentally retarded.
6. A tuition scholarship fund should be established to assist students willing to return to South Dakota, who wish to obtain special professional training not available in South Dakota schools, to pay the difference between out-of-state tuition and the cost that would be charged in South Dakota state supported schools.
7. Increased appropriations should be made to the State Commission for the Mentally Retarded to make it possible to provide additional staff to obtain records on the mentally retarded as indicated in existing statutes.

8. A statute should be added providing for a means of regaining "mental competency" when the mentally retarded person is ready to return to society as a productive citizen.
9. A statute should be added to provide for exemption from bond through a bank or savings company under the guardianship of the State Commission for the Mentally Retarded for estates under $1,000, so that these small estates will not be depleted unnecessarily by the deduction of the yearly $20.00 payment for bond.
10. A coordinating agency should be established which would be responsible for encouraging proper programming for the retarded through other state agencies and encouraging cooperation with voluntary organizations in assisting in the best use of services.

Summary of Recommendations for Action by State Agencies

It is recommended that:

1. The Comprehensive Planning for Mental Retardation should be extended in cooperation with Federal programming available under Public Law 89-97.
2. Local sources of information and procedures for referral to other sources for treatment should be developed in all communities.
3. Placement of retarded persons needing nursing home care should be increased in private facilities designed to offer such care, instead of maintaining these retarded persons at the institution at Redfield.
4. Placement of retarded persons in foster care situations should be arranged when such placement would better meet the needs of the individual than institutionalization.
5. Family day care arrangements should be made for retarded persons when such placement would better meet the needs of the individual than institutionalization or when circumstances warrant care outside the institution while awaiting space at the institution.
6. Counseling service should be made available to parents of retarded children (even before the children reach school age) through the Office of Special Education.
7. Investigation should be made into the possibility of obtaining a psychologist to accompany the mobile speech screening team now surveying the state.
8. To insure the best possible means of developing an understanding on the part of all classroom teachers of the educational needs of the retarded, course work or course content should become a part of the training background of all certified teachers. Better utilization of special classrooms would thereby result.
9. Routine information pertaining to retarded persons should be exchanged as administratively agreeable by state agencies.
10. Potential employers of the mentally retarded should be made known to Vocational Rehabilitation Counselors by other agencies.

11. Evaluative services which involve the retarded should be extended at the State Training School and the State Penitentiary.
12. Increases in the number of staff that are desperately needed for patient care and treatment at Redfield and Custer State Hospitals should be provided immediately. Staff-to-patient ratios which are currently at or less than one-half the national averages should be increased at a minimum to approach national averages which are still below recommended standards. Salary increases must be provided in order to recruit the needed staff.
13. A renovation of existing facilities at Custer State Hospital should be undertaken, along with additional staffing, to attain maximum use of the existing facilities, and a long range program designed to absorb the population growth of the persons in South Dakota needing to be institutionalized.
14. The Board of Charities and Corrections should arrange for the employment of staff to investigate the possible social security benefits to be obtained for institutionalized persons.
15. Speech and hearing therapists should be employed at Redfield State Hospital and School to provide training for the deaf and hard of hearing mentally retarded and those with other speech and language problems.
16. The interpretation of "those mentally and physically able to benefit from an educational program" under which the School for the Deaf operates should be expanded to include a special class for the mildly retarded who would benefit more from the program provided at the School for the Deaf than from institutionalization at Redfield State Hospital and School.
17. The School for the Blind should extend services to include additional retarded persons having vision losses who would, through training, be able to benefit from a program designed to meet their needs.
18. Occupational therapy services should be available to the severely retarded blind persons at Redfield or Custer State Hospitals.
19. Materials dealing with facts about mental retardation should be developed and distributed by the Health Education Division of the State Department of Health to guidance counselors for use in health education classes in high schools and junior high schools.
20. More scientific and statistical pilot studies on mental retardation should be instigated in South Dakota.
21. Statistical studies of birth and infant records at Ellsworth Air Force Base Hospital and Rosebud Indian Hospital should be conducted to obtain comparison information.

22. More adequate methods of case finding must be employed to aid in the development of statistics of the mentally retarded.
23. For statistical purposes, a system for reporting the mentally retarded should be refined.
24. Information about the retarded should be readily available from records for research purposes.
25. The State Department of Health, Division of Public Health Statistics, should arrange with physicians for an acceptable system of reporting malformations.
26. Arrangements should be made for the establishment of a Public Health Nurse Training Center in the state to increase the availability of employable persons for this profession.
27. Recruitment of more persons interested in taking training in special education teaching must be encouraged.
28. Speech therapy training to provide for requirements of certification should be initiated at the University of South Dakota.
29. Arrangements should be made through college extension divisions to offer courses by experts to persons wishing to obtain additional professional work in the field of mental retardation.

Summary of Recommendations for Communities and Local Governments

It is recommended that:

1. Comprehensive facilities offering care and training for the mentally retarded of all ages should be built. Federal matching funds are available under PL 88-164 to assist in construction.
2. Residential educational centers should be established to serve those retarded children living too far from the special education classrooms to travel daily.
3. Sheltered workshop programs should be expanded, including residential facilities, to serve those retarded persons living outside the cities where workshops are located.
4. Special education classes should be established in all schools having an enrollment of 200 or over who do not have classes for the retarded at the present time.
5. Vocational education, which is now developing in South Dakota, should be available to the mentally retarded students who might benefit from these programs.
6. Preschool training for the retarded should be developed through various sources as the needs become apparent in each area.
7. Arrangements should be made for the establishment of public health nursing services in areas not now being served.
8. Regional centers should be developed to which private physicians may refer patients for evaluation and treatment.
9. Recreational programs should include retarded persons as a part of their number to be served.
10. Training for the proper use of leisure time should become a part of any training program, such as educational, institutional, or adjustment training.

Summary of Recommendations for the South Dakota State Medical Association and South Dakota Hospital Association

It is recommended that:

1. The South Dakota State Medical Association should make arrangements to enlist individual physicians who have special knowledge in certain medical practices to form teams to help inform other physicians concerning new methods in medical practice.
2. South Dakota physicians should encourage persons having a high possibility of incidence of mental retardation in their families to voluntarily seek appropriate medical examinations and consultation concerning these conditions.
3. The appropriate committees of the South Dakota Hospital Association and the South Dakota State Medical Association should investigate the feasibility of establishing premature baby care centers and exchange transfusion centers within the state.
4. Physicians should keep close watch on reports from all sources concerning immunization procedures of infants and expectant mothers, so that changes in procedures may be considered when appropriate.
5. Expectant mothers should not be vaccinated for smallpox because of possible effects of the vaccination on the fetus.
6. Expectant mothers should be given Salk polio vaccine instead of the oral Sabine vaccine.
7. The South Dakota State Medical Association should make arrangements with the State Department of Health, Division of Public Health Statistics, for an acceptable system of reporting malformations.
8. The South Dakota State Medical Association should investigate needed improvements in the system of reporting communicable diseases.
9. The South Dakota State Medical Association should give consideration to further study of potential causes of mental retardation in children, such as accidental poisonings from common products.
10. The South Dakota Hospital Association should determine the needs for the establishment of additional laboratory technician training schools and encouraging more if they are deemed necessary.

Summary of Recommendations for Private and Volunteer Organizations

It is recommended that:

1. Religious education training should be available to the retarded in all communities in South Dakota.
2. Private welfare agencies should be made aware of needed services for the retarded of all ages.
3. Information should be provided on an ongoing basis to county commissioners, county judges, and other persons directly involved in decisions affecting the mentally retarded, as resources are developed and treatment philosophies change.
4. Information should be supplied for use in professional journals most frequently used by professional persons as a means of continuing to inform them about mental retardation.
5. The South Dakota Association for Retarded Children and its local chapters should consider it their obligation to work for the implementation of all recommendations presented within this report of Comprehensive Mental Retardation Planning.

INTRODUCTION

The first settlers entering the vast prairie land that was later to become South Dakota labeled it "the jumping off place". Today, those to whom South Dakota is home, however, have chosen to label their state "the land of infinite variety", and appropriately so. The mountainous Black Hills area of western South Dakota contrasts sharply with the rolling prairie surrounding it. The mighty Missouri River which runs through the center of the state is bordered on either side by a valley which breaks into rolling hills, and flattens again to meet the vast prairie.

Much of South Dakota's variety can be attributed to its weather. The temperature drops far below zero during the freezing winters (-30 to -40 is not uncommon) and rockets almost unbelievably during the heat of the summer months to temperatures far above 100°, the highest recorded to date being 117°.

The wide open spaces which greeted the settlers are still much the same, now sprinkled with a sparse population, most of which is rural.

The vast area, extreme climate, and sparse population of South Dakota are the major factors in the problems of communication and public information. In this state, where 92.07% of the total area is farm land[1], (the average South Dakota farm covers 818 acres) passing information from neighbor to neighbor often involves many miles of travel.

South Dakota has a total area of 77,047 square miles and a total population of 680,514. The state is comprised of 67 counties, the largest in area being Meade County, which covers approximately 3,400 square miles, but boasts a total population of only 11,931. The three smallest counties in area are each approximately 400 square miles in size, having populations of 16,574; 10,764; and 4,552 respectively (Davison, Clay and Hanson counties). Of the 67 counties in South Dakota, 9 have populations of 3,000 or less; 3 have populations of 3,000 to 4.000; 10 have populations of 4,000 to 5,000; 23 have populations of 5,000 to 10,000; 13 have populations of 10,000 to 15,000; 4 have populations of 15,000 to 25,000; 2 have populations of 20,000 to 30,000; and 3 have populations of over 30,000; these being Brown County with a population of 32,617; Pennington with 57,731; and Minnehaha with 85,940.

There are eight cities with populations of 10,000 or over, the largest being Sioux Falls with approximately 70,000. Next are Rapid City with approximately 43,000; Aberdeen with approximately

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[1] Statistical information taken from the 1964 General Information Digest of the Greater South Dakota Association.

23,000; Huron and Watertown with approximately 14,000 each; Mitchell with 12,500; Brookings with 10,500; and Pierre, the State Capitol, with a population of 10,000. With the exception of Rapid City which is located approximately 40 miles from the western border of the State, all of these cities are located east of the Missouri River. One city has a population of 9,000 and only 4 others have populations approaching 5,000. By contrast, 244 towns listed on the 1964 South Dakota Highway map have populations of less than 500.

Limited professional personnel in the areas of public health nursing, social service, counseling, and related areas has contributed to the problems of lack of public awareness and coordination of programming for the mentally retarded.

It is felt that the recommendations contained within this Plan, having come from those who know the state best—its citizens—are necessary and realistic approaches to meeting the needs of South Dakota's mentally retarded.

METHOD OF PLANNING

One of the provisions of the "Maternal and Child Health and Mental Retardation Planning Amendments of 1963" (P.L. 88-156, approved October 24, 1963) authorized a one time Federal appropriation of $2.2 million to assist the States in planning comprehensive action to combat mental retardation.

As stated in the law, "Any such grant to a state . . . . may be used by it to determine what action is needed to combat mental retardation in the State and the resources available for this purpose, to develop public awareness of the mental retardation problem and of the need for combating it, to coordinate State and local activities leading to the various aspects of mental retardation and its prevention, treatment, or amelioration, and to plan other activities leading to comprehensive State and community action to combat mental retardation."

South Dakota received the minimum grant of $30,000 on July 1, 1964. Because of the fact that the Federal grant could not exceed 75 per cent of the cost of the planning and related activities involved, $10,000 had to be provided from South Dakota. The South Dakota Association for Retarded Children provided these matching funds by loaning its Executive Director to the South Dakota State Department of Health to fill the position of Director of Mental Retardation Planning on a half-time basis for the eighteen month planning period.

The law authorizing the mental retardation planning grant to South Dakota specifically urged community involvement in the planning activities. The planning staff cooperated in every way with the request.

The South Dakota State Department of Health was authorized to administer the grant for planning. The planning operation was the responsibility of the Mental Health Section.

Before the grant was approved, a Congress on Mental Health and Mental Retardation was held in Pierre. Over 300 people from all areas of South Dakota attended this meeting, May 15 and 16, 1964. Following this meeting the guidelines for the mental retardation planning project were developed.

A State Coordinating Committee for Planning was formed of representatives from thirty-one state agencies and interested groups. This committee had the responsibility of coordinating the planning activities of mental health and mental retardation. The specific duties of the committee were (1) to advise the State Health Officer on the scope of planning, methods and procedure, and public relations policy; (2) to select all committee chairmen of the State Council on Mental Retardation; (3) to work with the State Council on the development of the statewide plan; and (4) to assign priorities to the final recommendations in the plan.

An Executive Committee was then appointed from the members of the Coordinating Committee. This Committee was to have direct responsibility for the development of the mental retardation final plan. This committee worked in very close contact with the planning staff as well as with the fifteen state committees which made up the State Council.

After the establishment of the Coordinating Committee and the Executive Committee, the next step in planning was to activate the fifteen state committees. As was mentioned earlier, the Coordinating Committee appointed the chairmen of these committees and the planning staff worked in cooperation with the Executive Committee in the formulation of the committees. The Committees, each formed to study, on a statewide level, one specific problem or service area concerning mental retardation, were then given directives in the form of committee charges. The committees obtained their information in various ways using all sources available. (For a listing of the members of the committees, see Appendix.) Each of the Committee's reports are included in the Final Plan.

The community involvement, as mentioned previously, was felt to be one of the most important aspects of the planning project. In order to accomplish this community involvement, South Dakota was divided into various regions and sub-regions. Attempts were first made to hold regional and sub-regional meetings; but the traveling distance in South Dakota proved too great for any large scale regional participation. County chairmen were selected at these regional meetings and, in this way, the planning activities were brought directly into each county. It was at this time that the Executive Committee directed the planning staff to organize committees for each county. Each county committee was then asked to survey its county, by personal contact, using an attitude and opinion questionnaire prepared by a special committee. When the surveys were completed, the results were tabulated through the use of data processing equipment at the

University of South Dakota. The information was used to assist in forming committee recommendations.

Twelve Mental Retardation Planning Workshops were held after the county surveys had been completed, and more specific information was obtained on a regional basis.

It is estimated by the planning staff that 4,000 individuals participated in the planning project. The cooperation received from the various state agencies, public and private organizations was excellent. Without this cooperation, a comprehensive plan of action would not have been possible.

DEFINITION OF MENTAL RETARDATION

There are good reasons for difficulty in formulating a universally acceptable definition of mental retardation. Mental retardation is a condition, or a collection of symptoms, rather than a specific disease entity. Mental retardation has dozens of known causes as well as perhaps hundreds of unknown causes.

From a medical point of view, "mental retardation" is a syndrome which can be produced by many causative agents acting singly or in combination. Symptomatically, it is characterized by delayed or atypical developmental patterns accompanied by impairment of general adaptation. From an educational point of view, the mentally retarded child is characterized by subnormal intellectual function to an extent which prevents him from responding efficiently to the usual patterns of classroom instruction. From a social standpoint, the retarded child is slower in maturing and acquiring social and practical skills; as an adult, the retardate has less than the normally expected ability to manage his affairs and to progress in gainful employment.

Many definitions of mental retardation have been formulated. The one currently accepted by the American Association on Mental Deficiency, as well as by the South Dakota Mental Retardation Planning Authority, is: "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."[1] "Mental retardation" thus encompasses a wide range of deviance, from minimal to profound. The distinction between normality and the mildest degree of mental retardation is arbitrarily defined. Mildly retarded persons are more comparable to those who are normal than they are to the most profoundly retarded. For this reason, although there are many more near-normal retarded than profoundly retarded, fewer specialized services and facilities are required for the mildly retarded.

Generally speaking, categories of services are established according to the practical level of functioning and age, rather than the cause of retardation. Nevertheless, etiology may have to be considered in the specifics of treatment or education for a particular individual. Practical distinctions must, therefore, be based on extent of impairment, taking account of the various factors which contribute to intellectual and social functioning. The manifestations of these levels of function change with age. These are indicated in abbreviated and qualitative form in the accompanying chart.[2]

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[1] Heber, Rick, "A Manual on Terminology and Classification in Mental Retardation," *American Journal of Mental Deficiency,* Monograph Supplement, Second Edition, 1961, P. 3.

[2] U.S. Department of Health, Education, and Welfare. *Planning of Facilities for the Mentally Retarded.* Washington. D.C., November 1964, P. 3.

DEVELOPMENTAL CHARACTERISTICS OF THE MENTALLY RETARDED[1]

DEGREES OF MENTAL RETARDATION	PRESCHOOL AGE 0-5 Maturation and Development	SCHOOL AGE 6-20 Training and Education	ADULT 21 and over Social and Vocational Adequacy
MILD	Can develop social and communication skills; minimal retardation in sensorimotor areas; often not distinguished from normal until later age.	Can learn academic skills up to approximately sixth grade level by late teens. Can be guided toward social conformity.	Can usually achieve social and vocational skills adequate to minimum self - support but may need guidance and assistance when under unusual social or economic stress.
MODERATE	Can talk or learn to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision.	Can profit from training in social and occupational skills; unlikely to progress beyond second grade level in academic subjects; may learn to travel alone in familiar places.	May achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.
SEVERE	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training.	May contribute partially to self-maintenance under complete supervision; can develop self - protection skills to a minimal useful level in controlled environment.
PROFOUND	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Some motor development present; may respond to minimal or limited training in self-help.	Some motor and speech development; may achieve very limited self-care; needs nursing care.

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[1] U.S. Department of Health, Education, and Welfare. *Mental Retardation Activities of the U.S. Department of Health, Education, and Welfare.* Washington, D.C., U.S. Government Printing Office, July, 1963, P. 2.

ADMINISTRATIVE REPORT

During the time of the development of Comprehensive Planning for Mental Retardation in South Dakota, the Legislature passed a resolution calling for a Legislative Research Council study of the needs of State support to adjustment training centers (sheltered workshops). A sub-committee of the Health and Welfare Committee was appointed and began gathering and evaluating data concerning the operation and financial needs of the existing adjustment training centers. A similar sub-committee was studying the needs of mental health centers. The two sub-committees were called together to consider administrative handling of proposed State appropriations.

The proposal which was adopted by the joint sub-committees and subsequently by the Legislative Research Council for presentation to the 1966 Legislature called for the creation of a Commission of Mental Health and Mental Retardation. The duties of the Commission are to coordinate departmental programming for mental health and mental retardation, to cooperate with Federal agencies and private organizations in programming to meet the needs in the fields of mental health and mental retardation, and to administer State funds appropriated for the subsidization of mental health centers and adjustment training centers.

At the time of this writing, the 1966 Legislative Session has not yet convened, and therefore no formal legislative committee hearings have been held concerning the proposed Commission. This will be the first effort by the Legislature to establish a coordinating agency for programming in mental retardation. No appropriation for adjustment training centers has ever been passed. The need for coordination of programming and the establishment of an administrative means of distributing financial support to the adjustment training centers was thoroughly established by the Legislative Research Council's Study.

Therefore, it is recommended that a coordinating agency should be established, responsible for encouraging proper programming for the retarded through other State agencies and encouraging cooperation with volunteer organizations in assisting in the best use of services.

PUBLIC HEALTH AND PRENATAL CARE

The Committee on Public Health and Prenatal Care addressed itself to the problems concerning improvement of conditions surrounding the birth process, the utilization practices by the public of existing facilities, and needed facilities. To reach conclusions about the quantity and quality of prenatal care in South Dakota, information was gathered and evaluated as to the percentage of births taking place in hospitals, the fetal death rate, and the complications surrounding the births.

Evaluation of the information indicates that the premature birth rate in South Dakota is lower than the national average, but the premature death rate is approximately 50% higher. Causes of the specific fact cannot be conclusively isolated, but probably steps can be taken which, when coupled together, will tend to improve the conditions which are undoubtedly contributing to the higher premature death rate and are likely to increase mental retardation.

It is recommended that physicians keep close watch on reports from all sources concerning immunization procedures of infants and pregnant women. The procedures being used appear to be acceptable at the present time, but more scientific information is being made available periodically which may cause physicians to consider changes.

It is recommended that pregnant women not be vaccinated for smallpox because of the possible effects of the vaccination on the fetus.

It is recommended that pregnant women be given Salk polio vaccine instead of the oral Sabine vaccine.

It is recommended that funds be made available to finance medical students in doing statistical studies of the birth and infant records at Ellsworth Air Force Base Hospital and the Rosebud Indian Hospital. Because of the controls possible in these two units, invaluable information could be obtained with minimal cost. A contrast study could be made of urinary tract infections. Because of the questionable importance of these infections in premature births, physicians should be urged to become more aware of the possible problems resulting from the infections and should be alerted for the symptoms.

It is recommended to the South Dakota State Medical Association that arrangements be made to enlist individual physicians who have special knowledge in certain medical practices to form teams to help inform other physicians concerning new methods in medical practice.

It is recommended that the South Dakota Legislature appropriate $15,000 to establish and finance a cytogenetics laboratory service at the University of South Dakota School of Medicine. Establishment of cytogenetics services and the application of the information obtained could lead to prevention of mental retardation in a predictable number of cases.

State participation in encouragement of establishing additional county public health nursing services should be investigated by the South Dakota Legislature, inasmuch as there are only 23 counties in South Dakota in which public health nurses are serving at the present time. Public Health Nursing services have proven to be an invaluable source of support to both physicians and families not only in dealing with instances of mental retardation, but with other public health problems, as well. Recruitment of public health nurses in areas most in need of such services remains a serious problem.

It is recommended that the Public Health and Prenatal Care Committee continue to meet as often as deemed necessary by the group, in order to continually plan and assess the progress in this field. The activities of this Committee should become an important part of the extended planning under PL 89-97.

PRIVATE MEDICAL PRACTICE

TRAINING OF PHYSICIANS

South Dakota has an outstanding two-year medical school at the University of South Dakota in Vermillion. No courses on causes, diagnosis, or evaluation of mental retardation are offered in the curriculum. It is doubtful that the separate courses could be offered in the present program. Further emphasis on inborn errors of metabolism which cause many of the defects of mental retardation could be requested for the medical students.

It is suggested that the Medical School, utilizing the Departments of Biochemistry and Pediatrics, present a symposium on mental retardation to the medical students and to the physicians and private practitioners throughout the State.

The best method of distributing new information to practicing physicians is through the Medical Association. Information such as a diagnosis and referral chart, a concise compendium of the existing inborn errors of metabolism, and pamphlets containing new information should be developed by the appropriate committees of the State Medical Association.

A panel of specialists, selected on a statewide basis, with interests in the fields of mental retardation, could meet yearly to review progress and areas of prevention, causes, diagnosis, and treatment, and could compile this information for dissemination to interested physicians and organizations throughout the state. This panel could also consider family counseling services regarding genetic problems.

RELATIONSHIP OF PRIVATE PHYSICIANS TO STATE AGENCIES AND ORGANIZATIONS CONCERNED WITH MENTAL RETARDATION

No new committees need to be established for the purpose of improving liaison and communications between the State Department of Health and the private physicians. The existing council structure of the South Dakota State Medical Association is felt to be the best possible means of providing for existing and future needs. Communications between the private physicians and other organizations can also best be handled through the Medical Association's Council structure. This arrangement appears satisfactory in the case of the South Dakota Association for Retarded Children, inasmuch as its state office is located in the same city as the South Dakota Medical Association and the Executive Directors of these units have excellent relationships and communications. Because of the relatively small population of the state, this arrangement is satisfactory.

LEGISLATION CONCERNING PRIVATE PHYSICIANS

No new legislation for the protection of privileged communications or rights of physicians is needed.

No new legislation should be adopted concerning the reporting of suspected or known cases of mental retardation. No mandatory testing for metabolic disorders is necessary.

REFERRAL FOR DIAGNOSIS, TREATMENT AND EVALUATION

Regional centers for evaluation and treatment, to which the private physician can refer patients, are sorely needed. Such centers should include the services of pediatricians, psychologists, psychiatrists, neurologists, orthopedists, physical therapists, occupational therapists, speech and hearing therapists, and social case workers.

The function of such centers should be to make a thorough evaluation of the case, recommended further treatment, if warranted, and return the information to the referring physician for follow-up.

Such diagnostic centers could be privately sponsored and the patient or his family should make arrangements for the cost of the services.

The services should be available not only for those where mental retardation is known or suspected, but for all types of medical problems. The services should be used at various periods in the life of the retarded person for reevaluation as conditions change. Periods likely to suggest reevaluation would be as changes occur from infancy to school age; at the onset of adolescence; as adulthood is reached; and as the person declines in ability due to age. Vocational planning and employment will need special attention. Anytime major changes in accomplishments or deteriorations occur, reevaluation may be needed. The interpretation and life planning should be the joint responsibility of the social case service of the diagnostic center and the referring physician.

EARLY DIAGNOSIS, TREATMENT AND EVALUATION

To provide necessary services for a workable system of diagnosis, treatment, and evaluation of mentally retarded persons in South Dakota, a statement of existing conditions must first be attempted.

Diagnostic centers with multiple services do not exist. Many of the services may be obtained through various means, but not in any central location or under any specific authority or system. Persons requesting such services usually begin with the family physician. The physician may make a referral to other physicians for special assistance such as pediatric, orthopedic, psychiatric, or neurological. Less frequently the physician refers the case to a psychologist, speech therapist, or public health nurse. In many instances the time lapse from the original contact to the time when the various referrals are complete is tremendous. If several referrals are made, the combined diagnosis and recommendations for treatment and prognosis may be disjointed, confusing or even appear to be in conflict. As a result of the lack of interpretation or understanding and acceptance on the part of the family of the retarded person, other resources may be sought. In many instances this may contribute to the confusion. Occasionally when other resources are sought, nonprofessional persons or professional persons dealing outside the area of their professions, may misguide the family. Even when proper professional recommendations are made, the family may not be psychologically ready to accept the recommendations which are presented, at least at the time and in the manner they are given. This dilemma suggests that there may continue to be problems of this nature for quite some time. The solutions can only be found in better public understanding, acceptance of the retarded, and appreciation of the traumatic experience being encountered.

Nevertheless, some improvement needs to be made to reduce the confusion which exists at present. No diagnostic facility exists. No central location contains all of the necessary services to perform the task of a diagnostic facility. Several areas have most of the professional specialties which might be needed, but no coordination exists and no one person or profession assumes the role of interpreting the diagnosis or making long range probabilities known to the families of retarded persons. Seldom are arrangements made for follow-up or reevaluation and readjustment of goals at periodic intervals.

Ideally, **there should be at least one Central Diagnostic Clinic** containing the following services for diagnosis: pediatrician, psychologist, social worker, public health nurse, neurologist, opthamologist, orthopedist, speech and hearing clinician, physical therapist, occupational therapist, psychiatrist, radiologist, and pathologist. Some of the above might best be available on a consultative basis, but the services should be readily obtainable. Other specialist services may be needed in some instances for special problems, but might not need to be available as readily as those mentioned above.

This Committee recognizes the need for **sub-stations of the Central Diagnostic Clinic to be located in various parts of the State.** If other diagnostic services, regardless of their location, can be put into operation before the central diagnostic system is developed, every encouragement and assistance should be offered by all levels of government and by private agencies.

Because many people are reluctant or unable to travel great distances, a system of screening those most needing the complete services of diagnosis might be initiated as a stated part of the State Department of Health annual Crippled Children's Clinics. Those found to be in need of more thorough diagnosis or those needing more time for evaluation could be referred to a diagnostic center. Many communities would like to have such a diagnostic center located in their vicinity, but the choice of location, geographically, is not nearly as important as the availability of the necessary professional personnel or the desire to have the services made available in the shortest possible time.

Families having the necessary financial resources to pay for such services as are required should have the opportunity to do so, but those unable to afford the services should not be denied equal opportunity. The cost for such services should be the obligation of the State when referral is made for their use from a qualified agency.

Records of cases diagnosed should be maintained so that proper follow-up and reevaluation at periodic intervals could be assured. Information obtained and recommendations made should be available to all qualified professional persons who might be providing treatment whether in public agencies or in private practice.

Research projects and statistical data should be permitted and encouraged to whatever degree deemed advisable **within the resources of the diagnostic center.** Application of principles determined from such research on metabolic familial disorders and blood factors can lead to prevention of several types of retardation in certain families having high probability of mental retardation factors.

Such diagnostic services should be available not only to persons known or suspected to be mentally retarded; but should also be available to persons with other types of handicaps.

FAMILY COUNSELING AND ASSISTANCE

One of the most frequently expressed concerns for services in the field of mental retardation as pointed out by the county reports and regional meetings, is the need for the family counseling.

Much of the counseling is done not on a formal basis, but through contacts parents of retarded persons make with others who have experienced similar problems. The local ARC units frequently serve as the means of establishing this kind of common ground.

Normally, the first professional person to have contact with a family who has a retarded child is the family physician. Results of this contact are somewhat variable, and the reasons for the variation of success are difficult to evaluate. A description of some of the circumstances may serve to partially explain the range of problems. On detecting the presence of mental retardation, some physicians have recommended immediate institutionalization of the newborn child. This type of recommendation is very rarely in keeping with the modern day philosophy of attempting most nearly to meet the needs of individual care for the child. It is neither possible to institutionalize a newborn infant at the state institution at the present time, nor is it psychologically practical within most families to cut themselves away from another member of the family to the extent likely to be required by immediate institutionalization of the infant. On the other hand, the physician who attempts to counsel parents in methods of care and training of the retarded child may find the family totally unwilling or unable to accept his advice. There may be guilt feelings associated with being the parent of a retarded child which cannot be overcome in the time and in the circumstances available to the physician.

The next professional person who frequently has contact in a counseling role is the clergyman. Again the results of counseling may vary, depending on the amount of information and knowledge the clergyman has about retardation, and his skill as a counselor.

Often in less formal counseling situations, school administrators and teachers are placed in a role of providing information and advice to the parent of the mildly retarded school age child. Only the very largest school systems have had psychologists or social workers on their staffs. The county reports and regional meetings indicate a desire on the part of many persons to have counseling services of some type available through the school system. Recommendations to meet this request are found in the section of this plan dealing with Education and Training.

The administration of the Redfield State Hospital and School is frequently contacted for advice, information, and counseling about institutional care and services for the retarded. This resource is unquestionably the most accurate source of information available, but because of the distance between Redfield and much of the population of the state, and the limited number of staff available, it can neither serve the entire state nor provide the time for follow-up needed to insure the best results in all cases.

Additional staff to counsel with the institutionalized retarded is needed as recommended in the section of this plan dealing with Dependent Living.

Less frequently contacted for counseling are public health nurses, social welfare workers, psychologists, and psychiatrists, and at still later ages vocational rehabilitation counselors and employment security counselors.

Less than half of the counties in South Dakota have public health nurses. Most parents of newly diagnosed mentally retarded children do not know that the public health nurse could be of direct assistance to them in working out care problems such as feeding, diet, and toilet training. The value of public health nursing is being more widely recognized and, as recommended in the section on Public Health and Prenatal Care, more public health nurses are needed.

The availability of state, county, city, and private social welfare workers to serve as a source of information and counseling outside of the area of financial assistance programs is not well known. Referrals of mental retardation cases to social workers by other professional people are infrequent.

The limited number of welfare staff makes further requests for more referrals unlikely. As recommended in the sections of this plan dealing with Day Care and Personnel and Manpower, more staff is needed.

Few psychologists and psychiatrists are available in South Dakota. Most of their available time in the past has been devoted to those persons demanding immediate attention because of a serious personality disorder. In recent years more Mental Health Centers have been established and the staffs are willing to do counseling with retarded persons and their parents. Because of the newness of this service, very few people realize its availability to assist in the area of mental retardation.

As stated in the section of this plan dealing with Vocational Rehabilitation, Occupation, and Employment, the quality of the services of the vocational rehabilitation counselors and employment security counselors is excellent, but more staff is needed.

Two significant problems emerge apparent that reduce the effectiveness of family counseling and assistance. The first is the lack of sufficient trained professional counselors as stated in the previous paragraphs. The second is the lack of a widely known source of reliable information in many communities. Therefore, in order to begin to utilize effectively the available lay and professional resources they must be widely known.

It is recommended that some person or agency be identified as a source of local information in every community. This source may be a physician, social worker, clergyman, teacher, psychologist, or lay person. The function of the local source will need to vary depending on the direct service the person or agency can provide. In the instance of a lay person identified as the source of information, he may be able to provide no direct service, but serve to refer the person to another person or agency for further information or direct services in a nearby community. In the case of a physician identified as the source of local information, he may be able to provide the service required himself, or make a direct referral for further service such as to a diagnostic center as called for earlier in this plan. Regardless of the professional background of the person serving as the local source of information, each community source should have listings of where to obtain various services, how to make application, and possible alternatives available. Literature should be available for distribution by the person or agency acting as the local source of information.

Regional training sessions for persons volunteering to serve as the local resources should be held to insure that basic information is possessed by all local persons serving as a source of information. Professional persons likely to have contact with the retarded and their families should be invited to attend and participate in the workshops.

Listings of the available local sources of information and services should be compiled and distributed to physicians, psychologists, psychiatrists, teachers, school administrators, clergymen, county judges, lawyers, states attorneys, public health nurses, social workers, rehabilitation and employment counselors.

The local public media should be supplied with information about the local source of referral on an ongoing basis and be asked to assist in keeping the general public informed of these sources and available services as they are developed.

The responsibility of the development of this project should rest with the future planning authority, but will require the cooperation of a vast number of persons and agencies.

DAY CARE

At the first meeting of the Day Care Committee, two major recommendations were made which needed to be carried out before other considerations could be met. These were: establishing the authority for licensure of day care facilities; and determining the extent of need for day care in general and in the specific case of the retarded. The 1965 Legislature passed a measure giving the authority for licensure of Day Care Centers and Foster Day Care Homes to the Division of Child Welfare of the State Department of Welfare.

The Division of Child Welfare established a State Day Care Advisory Committee. The State Day Care Advisory Committee and the Division of Child Welfare staff drafted standards for both the family homes and day care centers. The standards are available through the Division of Child Welfare (on file with the Secretary of State). The law and standards are adequate and acceptable to the committee. It is suggested that some person especially knowledgeable in mental retardation be appointed to the Advisory Committee.

Two separate surveys of day care needs were conducted by the Department of Health and the Division of Child Welfare. The Department of Health survey placed major focus on determining what facilities were available for day care service for the retarded child. The Division of Child Welfare survey assessed need for day care service. The determination was made that four facilities designed to provide day care for the retarded exist in South Dakota on a private basis. One additional day care facility for non-retarded children accepts a limited number of retarded children in their program (up to 10% of the maximum enrollment.) Cost to the parents in any of these facilities is normally prorated on the basis of ability to pay for the service.

Projects for establishing day care for the retarded are totally lacking in every part of South Dakota except Sioux Falls, Rapid City, Watertown, and Aberdeen.

The types of facilities which need to be developed to provide day care service are Day Care Centers and Foster Day Care Homes.

A Day Care Center is a place where children are cared for in groups of more than six children outside of their own homes for a part of the day. The average number of children cared for range from 25 to 50 children but as few as seven children can be desirable in some situations. The day care center has two major objectives:

1. To facilitate the adjustment of the child in his own home,
    (a) by providing relief for the parents for several hours during the day, allowing the mother to work, shop, or just relax her vigil;
    (b) by providing counseling services to the parents;
2. To provide a developmental program for the child while he is at the center.

Day care centers for retarded children take the following forms:

1. A community program designed to provide care for retarded children and assistance for their parents.

This includes programs which provide a service for retarded children who do not qualify for public school classes for the trainable or educable.

2. A program of preschool activity designed to help prepare retarded children for entrance into public school classes. Children of school age may be enrolled in these programs.
3. A center providing day care after school hours for children who attend day classes.

Day care centers provide many benefits to the retarded person, his family, and his community. Significant among them are: participation in supervised programs formally developed to meet individual needs, and maintenance of a controlled environment in which appropriate habit formation is a basic goal. These facilities also provide a wider range and type of experience than can be developed within the family. At the same time, the values of continuing participation in family life are retained. By using day care facilities, parents are afforded some relief from the 24-hour task of care and through participation in parent counseling programs offered by such facilities can obtain a better understanding of the problems of the retarded.

Many local resources are available for use as facilities for day care (church educational units, etc.) Persons interested in obtaining day care for their children, or organizations wishing to promote a much needed service in their communities could obtain assistance from child welfare offices in securing such services. The request for such assistance must be made before it is appropriate for the child welfare service to be initiated.

Thus, day facilities make it possible to keep the retarded at home and in the community.

A Foster Day Care Home is a family home where not more than six children are cared for outside their own homes for part of a day. These facilities need to be licensed by the Division of Child Welfare, State Department of Public Welfare as Foster Day Care Homes. Foster Day Care Homes may need to be the predominant type of day care service in rural areas where the establishment of day care centers is not feasible because of distance and lack of population centers. Foster day care is the most appropriate type of day care plan for specific children because of their age or special needs.

As a result of information gathered from the surveys taken in each county, it can be easily determined that day care is not well known as a means of meeting specialized needs of children. Day care for the child of the Indian, low-income, and migrant population is presently unavailable. Transportation (particularly in rural areas and in relation to the handicapped child) in relation to day care is often a problem. There is strong evidence that because of problems such as this, many very poor babysitting arrangements are being widely used. This is true not only in cases of handicapped children, but in general day care as well. It is not known that many services are available to offer assistance (not just financial assistance) through the child welfare agency, such as finding suitable day care family homes and placing children in them.

There is a definite need for some day care or foster care arrangement offering reliable care for children who are awaiting institutionalization and in cases where problems are being created in the family because of the constant presence of the retarded child. Projects of this type could be undertaken in any locality in the state to the extent that assistance is available. In some instances where facilities and staff are available in general day care, persons seeking care for retarded children may find these arrangements satisfactory. It should be understood that parents or others responsible for the child should be expected to pay a portion of the cost, depending on the means available.

Social casework service is an essential part of day care service.

Caseworkers have special knowledge about human behavior and family relationships and have special skills in helping with problems centered in them. They can help parents and other professional workers to understand and meet the developmental needs of the young child as a member of his family and the needs of the family as members of a community.

The caseworker works with the parents and with the family day care mother or the day care center staff. She helps parents understand what the problems are that the child is struggling with, the meaning of his behavior, and how the parents, the family day care mother, or the day care center staff can work together to help him.

Often the caseworker can help parents to recognize the strengths in their relationships with their children or enable day care workers to see ways of capitalizing on these strengths in working with the parents.

The caseworker may also be able to help the family day care mother or the day care center staff understand the child and his needs better as a result of her knowledge of his background and his family. When several agencies or professional workers are concerned in helping the same family, this sharing of information and knowledge becomes particularly important. The caseworker can interpret the specialized services of other agencies to parents and to day care workers in an effort to preserve a coordinated approach by all those working together for the welfare of the child and his family.

It is recommended that family day care arrangements be made for those individuals desiring day care for the specialized case or in areas where establishment of larger units is unfeasible because of distances or lack of population centers. Small units should not be considered undesirable. Though the average unit for general day care ranges from twenty-five to fifty, licensing of units designed for six or more is required. Even when the unit is less than six, the services of welfare workers is available.

Financial assistance is available, such as for pilot projects through the Department of Health, Education and Welfare, and advisory assistance is now available from the Child Welfare Day Care Advisory Council. It is felt that any reasonable project presented through proper channels from South Dakota would be given thorough consideration for federal funds for assistance as a pilot project.

In order for the Division of Child Welfare to be in a position to offer the needed service **more social case work staff and licensing personnel are needed** and more will be needed to carry out the requests for assistance as the service is more accepted and understood. Support for staff increases are essential now and will need to be continued until sufficient numbers of staff are provided to give the required service and protection needed by children who are retarded. More programs should be available for the educating of day care personnel. Training institutes could be held in various locations within the state, providing a means of further education for staff members from existing day care facilities, and for those interested in initiating additional day care services. Training through similar means should be available to social case workers and other professional personnel who might be working with day care units and the families using day care services.

EDUCATION AND TRAINING

Information concerning the problems, needs, and possible solutions to education and training of the mentally retarded was gathered by the committee. Sources of information included questionnaires circulated to school administrators, county superintendents, and school board members for detailed responses, and the general questionnaire from a greater sampling of individuals in various professions. Background information was also obtained from the Office of Special Education of the Department of Public Instruction. Recommendations coming from the regional meetings were also valuable sources for determining ways of meeting the needs.

The Division of Special Education was created in South Dakota in 1953. In 1962 the Division was changed and placed under Pupil Personnel Services. It is presently known as the Office of Special Education. The Office is currently assisting 92 special education classrooms having a total enrollment of 976 students. Financial support to the classrooms is established by the Department at the annual rate of $1,800.00 for each classroom meeting the standards and approved by the Office. Statutes enacted during the most recent legislative session and going into effect on July 1, 1965, prescribe that each county special education fund will pay tuition at the same rate as secondary school tuition to the school maintaining the special education class to which the child is assigned by the Office of Special Education. Transportation at the rate of 7c per mile, not to exceed $1.50 per day, is payable by the school district in which the child resides. In the event the child is boarded away from home for school purposes, the $1.50 per day may be substituted for board and room in lieu of transportation. The Office of Special Education provides for testing of children, assignment to special classes, and supervision of the classrooms. Special needs for services such as speech therapy may also be authorized by the Office. No limitation on programming is made except that of the upper age limit of 21.

From all sources checked by the committee, the indication is that **the greatest need in the area of education is** unquestionably **that of providing adequate counseling services to the parents of retarded persons, including preschool age retarded**, and to the young retarded person himself. Several approaches have been suggested as possible solutions in different parts of the state. The most frequently suggested solution (particularly in the central and western part of the state) is that the State Department of Public Instruction's Office of Special Education provide counseling service on a multi-county basis. Such counselors would then be free of pressures of any one school district or county or any of its officials. This would enable them to do a more effective professional job of counseling and psychological testing, including the much needed counseling with parents following testing, which is most frequently cited as the point where many problems arise.

The second solution offered is the encouragement of the employment of counseling personnel by more school districts on an individual basis or by contracting to cooperate in the employment of one counselor by two or more districts.

The third solution is that of further utilization of counseling service now available in the existing Mental Health Centers on a private individual basis.

The second most apparent need in the area of education and training for the mentally retarded in South Dakota is that of still further opportunity for **special education classes for** the academically oriented elementary school age child. It appears that **all elementary schools having an enrollment of 200 or more students have need and could logically sustain at least one such class.** There are still 66 schools in South Dakota of that size that do not have a classroom. The machinery to establish them is present, but various reasons of a local nature have so far deterred the local districts from establishing them. The most frequently mentioned reason is the lack of available funds in the district to initiate an additional program.

The county special education tuition fund has not been in existence long enough at this time to permit any indication of what effect it may have on this attitude. School boards, superintendents, and the Office of Special Education should continue to provide leadership in working out cooperative arrangements for providing special education rooms.

There will continue to be many areas where no special education classroom can be developed because of limited population within a logical distance for people to travel on a daily basis. To meet the needs of persons from these areas, **it is recommended that boarding facilities be constructed to house students on at least a five-day week basis and provide an educational program to meet the needs**

of children from outlying areas. Such units should also be planned to take those students who do not fit into the programs offered in the special education classrooms for various reasons such as multiple handicaps, need for foster care, need for available medical supervision not available in smaller towns, etc. Units established for this purpose could also accept students who are incompatable with others in their local communities age-wise, or who need more special programming than can be provided at the school nearby. By locating such units in close proximity to the available sheltered workshops and adjustment training centers, the students could move from school to the shop training whenever such a move might be appropriate. Children should not be prevented from continuing because of reaching any specific age, but only when no further progress can be made.

Percentages of children needing classes designed to benefit the "trainable" or "life skills oriented" lead to the conclusion that an approximate enrollment of 1,250 to 1,500 elementary school age children would be necessary in order to expect to have a minimum of five to six "life skills" students in the territory to be served by the classroom. Proper location of such classroons in South Dakota becomes a more difficult problem because of the sparcely populated areas. The same provision for assistance by the Office of Special Education is available for "life skills" classrooms as that for the "academically oriented" classrooms, but many communities have not seen fit to establish "life skills" classrooms even where the need exists and numbers would warrant one or more such rooms. A number of school superintendents and school boards have not felt that programming for the "trainable" is a proper function of the public school.

The Legislature has included the "trainable" and the "educable" in the permissive legislation passed in 1961. The change to the county special education fund in 1965 may make a difference, but **the rate of establishment of special classes for the "trainable" should continue to be watched closely by the Office of Special Education.** If further financial assistance is needed in order to stimulate the programming in "life skills," it should logically come from the State through special appropriation or through the Office of Special Education. Special financial assistance would be justified in such cases because without the classrooms for the trainable, the only other resource available is the Redfield State Hospital and School, which is supported mainly through state sponsorship.

Vocational training, which is in its initial stages of development in South Dakota (the office of Vocational Education Act of 1965 went into effect July 1, 1965), is the next most urgent need expressed by the people participating in the planning activity and by the school superintendents and school boards specifically questioned. **It is therefore recommended that students who are enrolled in special education classes be considered as also eligible for part time or full time enrollment in vocational classes which are deemed to be appropriate for their needs.** No need for further legislation for vocational education is known to exist at this time.

Preschool training for the retarded through the public schools is non-existent in South Dakota at the present time. More significant than the demands for preschool training is the necessity of proper diagnosis and the necessary treatment which may be available if the condition is detected early. **Of immediate concern** to school superintendents and other persons associated with the retarded on a personal basis **is the need for counseling services to be available to the parents of preschool age children.** Once this has been established, some methods of providing preschool training should be initiated from the State through the Office of Special Education; where federal funds may be available, they should be utilized in investigating the need and, if proven to be advisable, in establishing and providing the programming.

Arrangements should be made to insure the best possible means of developing an understanding on the part of all classroom teachers in the public schools of the educational needs of the retarded. **Course work or course content should become a part of the training background of all certified teachers as soon as possible.** Such understanding could lead to better utilization of special classrooms.

VOCATIONAL REHABILITATION, OCCUPATION, AND EMPLOYMENT

The Vocational Rehabilitation, Occupation, and Employment report is divided into four sections: Employment Opportunities for the Mentally Retarded in Federal Service; Selective Job Placement by Employment Security; Selective Job Placement and On-the-Job Placement of the Mentally Retarded by Vocational Rehabilitation; and Adjustment Training for the Mentally Retarded.

Two major surveys were conducted: 1. Employer Attitudes; and 2. Support of Workshops in the United States.

EMPLOYMENT OPPORTUNITIES FOR THE MENTALLY RETARDED IN FEDERAL SERVICE

In a special message to Congress on February 5, 1963, President Kennedy proposed a broad national program designed to direct our national efforts toward alleviating the problems of the mentally retarded. President Kennedy followed this up with a memorandum on September 12, 1963, to heads of all executive departments and agencies. This memorandum stated in part "the federal government can demonstrate its leadership as an employer by identifying within the context of its employment program for handicapped persons those positions in which the mentally retarded can show their capability". It was to this end and in recognition of the special circumstances which will surround such employment that the Civil Service Commission modified its regulations and initiated the special authority to facilitate the employment of the mentally retarded in the federal system.

Effective September 30, 1964, the Civil Service Commission issued special authority to hire mentally retarded persons. This authority included a waiver of the ordinary procedure for examination of competitors for civil service positions. On April 22, 1965, the Civil Service Commission extended the one year authority from September 30, 1965, to September 30, 1968. Prerequisite to the use of this authority is the execution of a written agreement with the U. S. Civil Service Commission. Here are the critical elements of this agreement.

1. Statement by the agency of its support of the program and statement as to the specific positions, titles, grades and tasks to be assigned, the mentally retarded to be employed or a statement that such arrangements will be worked out at the local level in conjunction with the appropriate State Vocational Rehabilitation agency.
2. Statement by the agency that prior to employing a mentally retarded person, it will have obtained a certificate from the appropriate State Vocational Rehabilitation agency that the retarded person:
   (a) has the ability to perform the duties,
   (b) is physically qualified to do the work without hazard to himself or others, and
   (c) is socially competent to maintain himself in the work environment.
3. A commitment by the employing agency that it will fully utilize the advice and assistance of the State Vocational Rehabilitation agency for advice to the employee's immediate supervisor in the training supervision of the employee and for the post-placement counseling of the employee.
4. A statement that the agency will not terminate a mentally retarded person's employment without prior notification of the counselor concerned.
5. A plan for reporting on actions taken under this program. This is merely a means of feeding back information to the central agency headquarters on the inner workings of the program.

Although it may appear at first blush that employment of mentally retarded individuals runs counter to the continuing quest for quality in the federal community, an analysis of the situation in depth will reveal that there is no contradiction here. There are a number of jobs in the federal community which are of the relatively mundane processing-type which have had a history of employee dissatisfaction, rapid turnover, lack of motivation on the part of the employee, etc. These are the types of jobs for which a mentally retarded individual is unusually well-suited, particularly, in regard to his steady patience and his ability to concentrate on extremely routine tasks for long periods of time.

At times, it has been necessary to re-engineer positions in order to screen out the lower graded tasks and develop a single job which contains to a great extent the type of tasks which the mentally retarded employee is able to perform in an efficient manner.

The results of the use of the authority up to April 26, 1965, have been very gratifying. Nearly 450 appointments have been made in 28 agencies and mentally retarded persons have been hired for some 40 different types of jobs government-wide. The federal government's experience seems parallel to that of private business where similar programs for the employment of the mentally retarded have been carried on. Mentally retarded persons have seemed to be faithful, willing employees who perform well in simple repetitive tasks for which they have been fully trained and they tend to be more stable at such jobs than many employees with greater apparent potential.

This program was very quickly put into effect, for example, between January 8, 1964, and December 31, 1964, 26 federal agencies had hired at that time 344 mentally retarded workers. The breakdown under this is as follows: 177 were appointed in field activities and 157 in the Washington, D.C., area. To illustrate the wide range of positions that mentally retarded persons are employed in, here is a representative sample: typists, mail carriers, machine operators, money examiners, housekeepers, messengers, farm laborers, press cleaners, laundry workers and in other low skill occupations.

Inasmuch as the Federal program of employment of the retarded through the Civil Service Commission has been in operation a relatively brief period of time, the major problem in utilization is that of establishing the necessary contacts to encourage the individuals responsible for employment to make their desires known to Vocational Rehabilitation Counselors. Though announcements of the program have been made through the Federal offices and to the news media, much more publicity about the program and its success and potential is needed. During the time of the Comprehensive Planning for Mental Retardation in South Dakota, some placements have been accomplished in postal service occupations.

It is recommended that appropriate publicity concerning the program be developed by the Civil Service Commission. Assistance in distribution of information about the success of the program could then be given to Rehabilitation Counselors and others interested in placement of mentally retarded persons.

At this time the Civil Service Authority has been issued for a one year period and extended for an additional three year period.

It is recommended that the authority be re-extended and set up on a permanent basis as a part of the Civil Service Commission.

SELECTIVE JOB PLACEMENT BY THE SOUTH DAKOTA STATE EMPLOYMENT SERVICE

The State Employment Service provides specialized assistance to South Dakota's physically impaired, mentally restored and mentally retarded persons.

In each of the fourteen local offices of the Employment Service, there is assigned to a qualified staff member the primary responsibility for developing suitable job opportunities for the physically impaired, including those mentally retarded who are employable. These professional persons consider the capabilities of applicants and the demands of jobs so as to place applicants where these capabilities may best be used. The placement people also aid in coordinating the work of the office staff and that of other agencies, to assure best use of all community resources. The Employment Service cooperates with the Department of Vocational Rehabilitation and employer groups interested in the rehabilitation and utilization of handicapped persons, including the mentally retarded.

Many of the mentally retarded provided special services are previously identified by the Department of Vocational Rehabilitation, public schools having special education programs and the South Dakota Association for Retarded Children. Unfortunately, there is a portion of the retarded which goes unidentified and consequently, does not take advantage of these available services.

A January 1965 survey was conducted by the Administrative Office of the Employment Service among ten of its larger offices servicing collectively the largest number of applicants registering during calendar year 1964.

The final results of the survey revealed that sixty applicants were determined to be mentally retarded and of that number forty were placed on jobs. This is an impressive placement record considering that these placement people have many other duties to perform in the local office and often times find that there is not enough hours in a day to meet the total job development needs of the mentally retarded applicants. Additional trained staff is needed to improve this situation.

Additional assistance to the retarded may be available through the Employment Service under regular training programs because of recent amendments to the Manpower Development and Training

Act (MDTA). It is now possible to provide a combined program of both occupational and basic educational training in reading, writing, language skills and arithmetic for a period up to 104 weeks to unemployed individuals, who need such basic additional training to qualify for and benefit from occupational training. This can be an especially valuable resource for training additional numbers of retarded adults, in view of the small portion who now benefit from rehabilitation efforts in other programs.

During the past ten years, the Employment Service has developed a very close working relationship with the Department of Vocational Rehabilitation. Both agencies pool their efforts to find suitable employment for clients seeking jobs. The number of persons to be trained in the future will be increased considerably over the present number being trained. This means that more staff time will be needed by both the Employment Service and the Department of Vocational Rehabilitation to cope with increased job development services.

The national administration is strongly urging that states increase their activities in the areas of Rehabilitation and Job Placement of the mentally retarded as well as the mentally restored. If this is to be accomplished, more professionally trained personnel is needed to do the job. It can be concluded that if the State Employment Service is to expand placement services beyond what they are doing now for the mentally retarded, it will be necessary to have additional staff to provide the services.

It is therefore recommended that additional funds be provided so that three additional positions may be added, whose primary function would be to develop job openings for the mentally retarded which include more persons completing courses under the sponsorship of Vocational Rehabilitation. For example, one of the placement specialists could be based at Sioux Falls and could serve the Mitchell workshop on an itinerant basis from Sioux Falls. It would also be possible for this same individual to make employer contacts in Madison, Yankton and other towns in the area. The other two staff specialists could be assigned to Aberdeen and Rapid City, respectively, and would also be expected to serve other towns in the area, for the purpose of uncovering suitable jobs for applicants.

SELECTIVE JOB PLACEMENT AND ON-THE-JOB TRAINING BY VOCATIONAL REHABILITATION

To this point all job placement by the Division of Vocational Rehabilitation has been accomplished by the counselors in the district offices. The district office personnel are close to the job market in their area and have a reasonably good understanding of the availability of jobs in their communities. They also have a good understanding of the qualities of the retarded person they are trying to place.

The general procedure that has been followed is that using the knowledge mentioned above the counselor tries to fit the person into a suitable job.

The district personnel also make use of any other agency interested in the client. Other agencies find employment for our clients, and provide much assistance in providing information about job availability.

A placement counselor has been employed for the Redfield Training Project who will be traveling the state locating prospective employers, job opportunities, and developing community interest in the mentally retarded. He has accomplished some placement work for the State Hospital and School and in the future will work on placement for the Redfield Project and for all retarded served by the Division of Vocational Rehabilitation. The use of a placement counselor is not considered a panacea for the placement problems, but this counselor will be of much assistance in knowing where opportunities for employment are, and just what are the job requirements.

Through this means the Vocational Rehabilitation Division hopes to pull the whole state agency together in a coordinated effort to place the retarded on a fitting job and in a fitting community.

All Selective Job Placement efforts by Vocational Rehabilitation will be coordinated with the activities in this area by the State Employment Office and Local Employment Office personnel in charge of placement of the handicapped.

On-the-Job training is considered an important asset in placing a retardate in any job situation. The agency feels that, even with training, a person will fit into a job situation more smoothly if he is trained on the actual job for a period of time. This gives him time to acquaint himself with the specific job during a period in which he is not expected to maintain full production.

An on-the-job training situation also lets the employer know that Vocational Rehabilitation is interested in his welfare and is trying to absorb some of the costs accrued while training the client to be somewhat proficient on his new job.

The on-the-job training situation is used for primary training when no other source is available. This provides an opportunity for training in a field in which specific training is not available. Again the employer feels better if he is helped in the training venture. If the employer is amenable to the training situation, there is a better chance of his retaining the client after the training period comes to an end.

This is also another method of working a retarded person into the establishment or industry of the skeptic employer. Through an on-the-job training situation the skeptic employer has time to evaluate the retardate in a rational manner. It gives him an opportunity to see if a retardate can really work in his particular business.

The Division of Vocational Rehabilitation presently pays a monthly training fee to an employer who agrees to train a mentally retarded client in a specific type of employment. The number of months the training fees continue or are authorized is dependent upon the arrangements made for each individual case.

Experience over the years with on-the-job training has been a real success in some instances, while in other situations, the attempt for permanent placement failed. The Vocational Rehabilitation Division definitely feels, however, that if more employers would be willing to enter into an on-the-job training venture that there are numerous areas of work that the mentally retarded would work out in with a measurable degree of success and as a result, more of these handicapped persons could be permanently placed in practically every community throughout the state.

In other words, if given an opportunity for a trial period, considerably more persons so handicapped could be totally, or at least partially, self-supporting as a result of having been placed in a type of work they can handle capably.

More Vocational Rehabilitation Counselors are needed in order to adequately serve the caseload and backlog of individuals who have made applications or are on the job and need follow-up. Federal funds have been made available, but sufficient state matching funds to obtain the maximum in Federal funds have been lacking.

It is recommended that the Legislature appropriate additional state funds to be used to obtain additional Vocational Rehabilitation Counselors to provide more direct service to those needing the services of Rehabilitation Counselors.

ADJUSTMENT TRAINING FOR THE MENTALLY RETARDED

The only opportunities for sheltered employment and adjustment training have been provided through privately sponsored adjustment training centers located in Rapid City, Aberdeen, Mitchell, and Sioux Falls. These units are currently serving 120 retarded persons, as follows:

Rapid City: 35 male, 9 female
Aberdeen: 15 male
Mitchell: 16 male, 5 female
Sioux Falls: 32 male, 8 female

The types of programs offered in these units include wood working and repair; food preparation and other domestic services; rug making; assembly projects; sorting and packaging. Because of the limited facilities and the lack of adequate boarding or foster home arrangements, a limited number of trainees have been accepted by the centers. The demand for adjustment training centers is increasing, due to the fact that many students enrolled in special education classrooms are reaching the conclusion of the academic programs for the first time, and it is now recognized that continued training leading to employment or sheltered workshop opportunities is needed. It is anticipated that **the number of requests for sheltered employment and adjustment training will increase threefold in the next four to five years.**

It is unlikely that many new adjustment training centers will be opened in areas not now having one. Possible exceptions to this would be Huron, which has had one year of experience in operation of a center, and the possibility of a small facility being developed sometime in the future in Watertown if sufficient local contracts could be obtained to assist in the cost of operation.

It would be advisable for capital fund drive purposes, for the future planning of the workshops to include the consideration of a designated geographical area which centers could logically serve. It is proposed for purposes of consideration that Rapid City serve the entire area west of the Missouri River; that Aberdeen serve the counties of Potter, Faulk, Spink, Clark, Grant, Roberts, Day, Marshall, Brown, Edmunds, Walworth, Campbell, and McPherson; that until such time as the Huron unit may reopen, Mitchell should serve the counties of Kingsbury, Miner, Hanson, Hutchinson, Bon Homme, Charles Mix, Douglas, Aurora, Brule, Buffalo, Jerauld, Sanborn, Beadle, Hyde, Hand, Hughes, and Sully; Sioux Falls would then serve the remainder of the state, which includes the counties of Codington, Hamlin, Deuel, Brookings, Lake, Moody, McCook, Minnehaha, Turner, Lincoln, Yankton, Clay, and Union.

None of the existing Adjustment Training Centers has boarding facilities of its own, and arrangements for boarding must be made on an individual basis in order for persons living beyond driving distance on a daily basis to take advantage of the training facilities.

Because it has been necessary for the adjustment training centers to gain their major support for their operations from contracts and sale of products, it has been necessary for them to forgo training and variety in production in order to have sufficient income to remain open. This practice of concentrating on production instead of training has had the effect of limiting the placement of trainees, thereby tending to defeat the purpose of the adjustment training centers.

It is not logical to expect the adjustment training centers to be self supporting, and the local communities cannot be expected to contribute enough to support the operations needed to serve the vast areas yet unserved. **The units need to be expanded and boarding facilities planned for the number of trainees to be expected from outside the basic area. In order to support additional staff and training programs needed, support from the state tax base at approximately 1/3 the total cost of operation is recommended.** The remainder can continue to be derived from school county special education tuition, training fees from Vocational Rehabilitation, and parent fees or arrangements made by parents in the event that the trainee does not qualify for Vocational Rehabilitation and the parent is unable to pay the fees.

In addition to training fees, Vocational Rehabilitation now has limited funds available for expansion, equipment, and initial staffing of programming in Adjustment Training Centers. State legislation concerned with providing operational funds for adjustment training centers should in no way jeopardize local autonomy or the favorable relationships which now exist with state agencies such as the Division of Vocational Rehabilitation. It is therefore suggested that the Commission on Mental Health and Mental Retardation being proposed by the Legislative Research Council be limited in its authority, thereby permitting local control of the operation of adjustment training centers.

SOCIAL DEVELOPMENT, RECREATION, AND RELIGION

Recreational opportunities for the retarded adult in South Dakota are non-existent. Recreational opportunities for the retarded children in South Dakota are very lacking. Most efforts on the part of parents have been directed to obtaining or providing the vital needs of care and education and training for their retarded youngsters. There are a few instances in which Scout Troops, 4-H Clubs, special swimming classes and teen centers have developed and are proving successful. So far, these have been developed in the larger communities or have been the result of one or a small number of particularly interested or motivated persons. Camping or other summer recreational outlets have been carried out in communities. In most instances these have been open to those living outside the community, but the number availing themselves of the opportunity has been small. For the most part the attitude has been that recreation is a luxury which can be done without. This attitude appears to be changing, but its therapeutic and training value is still not widely recognized as evidenced by the low priority assigned to recreational programs as a need for programming for the retarded listed by the largest percentage of people answering the survey questionnaires. Leisure time recreation for adult retarded exists only for the young adults in workshops. No attempt has been made to establish other groups. Outside of the few population centers, recreation for the retarded is bound to be slow in developing. Community programs for recreation for the non-retarded are either non-existent or just beginning to be developed. For this reason the development of special recreation for the retarded is likely to be some time in developing. The best opportunity appears to be in getting the retarded included in regular recreation programs where they can participate and when staff are available who are trained to be cognizant of the limitations and abilities of the retarded. Examples of types of recreational programs where the retarded can achieve success are: 4-H, Scouts, etc. Therefore **it is recommended that institutions training recreational supervisors be encouraged to familiarize their students in the recreational needs of the retarded.** Further study on including the retarded in recreational programs designed for the non-retarded should be undertaken by future study and planning groups or individuals.

Recreation for adults not in a formal community or institutional setting is not likely to receive much if any consideration in the foreseeable future. Therefore **it is recommended that training for the proper use of leisure time be considered as a part of any training program, educational, institutional, sheltered workshop or religious education.** The necessity of the retarded adult persons being able to adequately find and utilize leisure time pursuits is emphasized by the fact that it has been proven that more trained retarded persons have difficulty in adjusting to social situations than to the working situations for which they have been trained. Religious groups designed to serve the young adult may wish to assume a responsibility in their communities to insure the "adjusting retarded person" a means of pursuit of leisure time and recreation.

RELIGIOUS EDUCATION

Religious leaders for the most part agree that the training needed for the retarded in whatever setting is basic and fundamental. The common factors in the early training are to establish a belief in God and His infinite power, wisdom, and love; a knowledge of right and wrong; obedience to authority; and respect for the rights of individuals in a social setting. If these factors can be more conveniently taught in an interdenominational setting, using basic materials, specific doctrines of faith can be overlaid when and if the child is ready to comprehend them. Without the basic factors being established early, there is seldom an opportunity to assimilate doctrinal materials later.

Chaplaincy service is unavailable at Redfield State Hospital and School and Custer State Hospital, except on a volunteer basis. It has been conclusively proven in many other institutional settings that the retarded can benefit not only in a spiritual way from having the opportunity to hear the Word of God. It is recommended that AAMD standards should be followed, indicating a necessity of providing for full time chaplaincy services at both institutions.

Religious education and training for the retarded is provided in several communities on an interdenominational basis. Other congregations provide special classes for the retarded of their own faith. Religious leaders serve as one of the foremost sources of counseling to parents of retarded persons.

It is universally agreed by religious leaders that the retarded person has every right to be accepted as a member of society and as a part of church leaders' responsibility for service. It is also mutually agreed that **retarded persons should** not only be accepted as part of society but should also **be respected as individuals.** If retarded persons have special needs for special religious service, these become the responsibility for service from those persons willing to accept the challenge of providing service to any human beings.

It is therefore recommended that the challenge of obtaining religious education be the joint responsibility of the South Dakota Association for Retarded Children, especially the local chapters, and the clergy and lay religious leaders. In order to assure a proper consideration in each community of the best utilization of available resources for religious education, it would be advisable for the ARC to arrange for training programs to be presented through the cooperation of organizations of Ministerial Associations. Such programs should offer a means of local use, where no religious education programs exist. The goals of the project should be:

1. To interest and inform the clergy and lay religious leaders in spiritual needs of the mentally retarded in their community.
2. To motivate the parents and the religious leaders to utilize available resources to effectively meet the religious needs of the retarded.
3. To familiarize the interested people with the materials and goals of religious education and to identify future leadership to carry on the project locally.
4. To further cooperation between the religious leaders and the parents of retarded persons.

Information gathered by the ARC during the time of the Comprehensive Planning indicates many communities are currently desirous of assistance in establishing such training sessions. Statewide or district church jurisdictions appear to be ready to aid in the support of the development of training and evaluation programs. Support of the project from these jurisdictions to their local member units should insure greater likelihood of success.

It is therefore recommended that volunteer training and evaluation programs be established in South Dakota as soon as possible.

GUARDIANSHIP, LEGAL PROTECTION AND PROCESSES

South Dakota Code 30.04 as amended governs commitment procedures for mentally retarded individuals to the State Commission.

Basically, each county's Sub-Commission consists of the county judge, states attorney, county director of public welfare, county superintendent of schools, and a reputable practicing physician appointed by the county commissioners (normally the county doctor).

While any citizen would have the right to sign an information alleging an individual to be mentally retarded, the usual procedure is for action to be instituted at the request of a member or members of the mentally retarded person's family. Upon filing such information with the County Court, time is set for hearing, the county doctor examines such individual, and the board observes such individual at the time of hearing. Usually the Board requests testimony from two witnesses concerning the capacity of the alleged mentally retarded person.

It is the practice of Redfield State Hospital and School not to accept anybody having an I.Q. of 70 or above and an I.Q. is normally determined either by Redfield State Hospital psychologist or by local competent authorities prior to the hearing.

Upon evidence before the local Commission as to I.Q. and surrounding data, the mentally retarded person is ordered committed to the State Commission. Copies of said order are forwarded to the State Hospital and School at Redfield and when the person is committed both to the State Commission and the State Hospital, the retarded person's name is placed on the Redfield waiting list. As soon as a vacancy appears at the Redfield State Hospital and School for the individual, the family is notified and at that time they have the option to either take the patient to the Hospital or to continue to care for the patient with the right of later placement subject to availability of space.

Committal procedures for most mentally retarded persons is a good "insurance policy" even though the intent of the family is not to transfer the individual to the Hospital, as the required procedures would place the individual on the approved list and space would be available in the event of unforeseen emergencies.

Section 30-4006 and 07 of the South Dakota Code deal with mandatory reporting to the state commission by teachers, doctors, county welfare boards, or commissions, all known or suspected cases of mental retardation. This statute is not followed in practice. **It is recommended that** while the statute itself needs no changing, in order for the statute to be effective **the State Commission should be more adequately staffed and financed** to enable it to carry out its duties of requesting such reporting.

Recognizing that the State Commission and other state agencies such as Pupil Personnel Services and Vocational Rehabilitation have experienced excellent cooperation in exchange of information pertaining to retarded persons, **it is recommended that a routine exchange of information obtained by each of these agencies be established** through a system mutually agreeable and arranged by the administrators of these agencies.

Sections 30-4006 and 07 of the South Dakota Code deal with mantion of the names of mentally retarded persons. Because no interpretation of the term "publication" has been made officially, some further clarification might be necessary within the wording of the statute if problems arise. It is recommended that any future problems arising of this nature be referred to the State Commission for their consideration. Lists of mentally retarded persons are maintained in the offices of the County Clerk of Courts. The statute does not prohibit the use of information from case files for purposes of research and is available to consulting agencies and persons having need of the information for good and proper reason.

It is suggested that further study be given to possible legislation to insure protection of the rights of the retarded in wills and probate proceedings. Some protection is given by the present law, but to insure further protection, the names of the parents of the retarded should be listed with the County Clerk of Courts (along with the list of names of the retarded which is presently recorded with the Clerk of Courts in each county.) Through this means, the necessary information would be available to county judges to provide a cross-check when wills are probated.

Section 30-0501 and 30-0510 relate to the subjects of sterilizations of those who have been adjudged to be mentally retarded and committed to the State Commission and the relationship to the gaining of mental competency. **It is recommended that an additional statute be included which would establish a specific procedure for restora-**

tion of mental competency. Such a procedure should include not only a mental evaluation, but also a study of the individual's social environment, performance in social situations, and other factors influencing his potential adaptability to the situation. Further review of Section 30-0510 of the South Dakota Code is recommended.

The problem of mental incompetency to stand trial and be responsible for one's acts in relation to criminal code appears to be left largely to the discretion of the judges. If the alternatives of probation to some other treatment or community facility are known and utilized by the judges instead of just institutionalizing the individual without regard to his treatment and training needs, no change is needed in the statutes. Judges do need to be informed about the availability of such services as they are developed.

The statutes dealing with guardianships of estates for a retarded person appear to be adequate except in the case of arrangements for bonds of small estates. The law requires the premium payment of twenty dollars per year for bond of an individual listed as guardian, payable by the estate. The protection offered by the bonding is good, but in the case of a small estate the expense soon depletes the fund. Individual working arrangements have been made to have a bank or savings company handle accounts under $1,000 with withdrawals made only by permission of the court, with no bond required. **It is recommended that estate arrangements be specifically permitted under the law or that some state agency such as the State Commission for the Mentally Retarded be authorized to serve as the guardian of such estates, with a waiver of bond.**

Placement of emergency cases in the institutions is a major problem for county sub-commissions and for families of the retarded. Temporary placement at the institution is also of concern to a number of families. Detailed consideration of these problems was made throughout the planning period. Some persons feel that plans should be made to expand the existing institutional facilities immediately so that waiting lists can be eliminated, the policy of not regularly admitting infants below two years of age be altered, and beds be provided for temporary care for family emergency and convenience. The majority of persons involved with the various committees, the state agency personnel, and the persons commenting on the subject in the county surveys feel that the more practical solution is that of **a long term plan of providing more community resources in order to prevent many institutionalizations and to assist the institution in community placements.**

The seriousness of the problem cannot be ignored but must be the concern of all future planning in the state[1]. It is suggested that a committee continue to review problems of the institutions of the mentally retarded in South Dakota.

Because of the need to inform those persons directly involved in decisions affecting the mentally retarded, **it is recommended that information be provided on an ongoing basis to county commissioners' meetings, county judges' meetings, and bar association meetings, as resources are developed and treatment philosophies change.**

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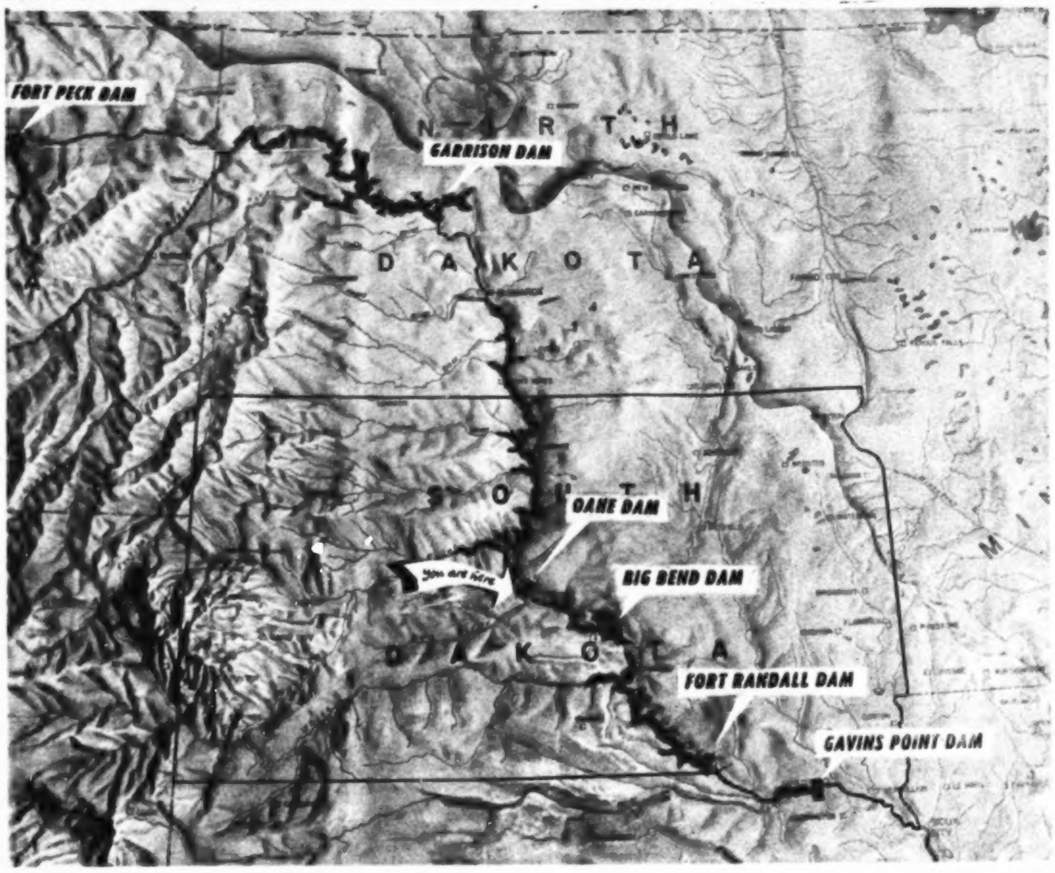
[1] See Dependent Living report for the details of the institutional needs.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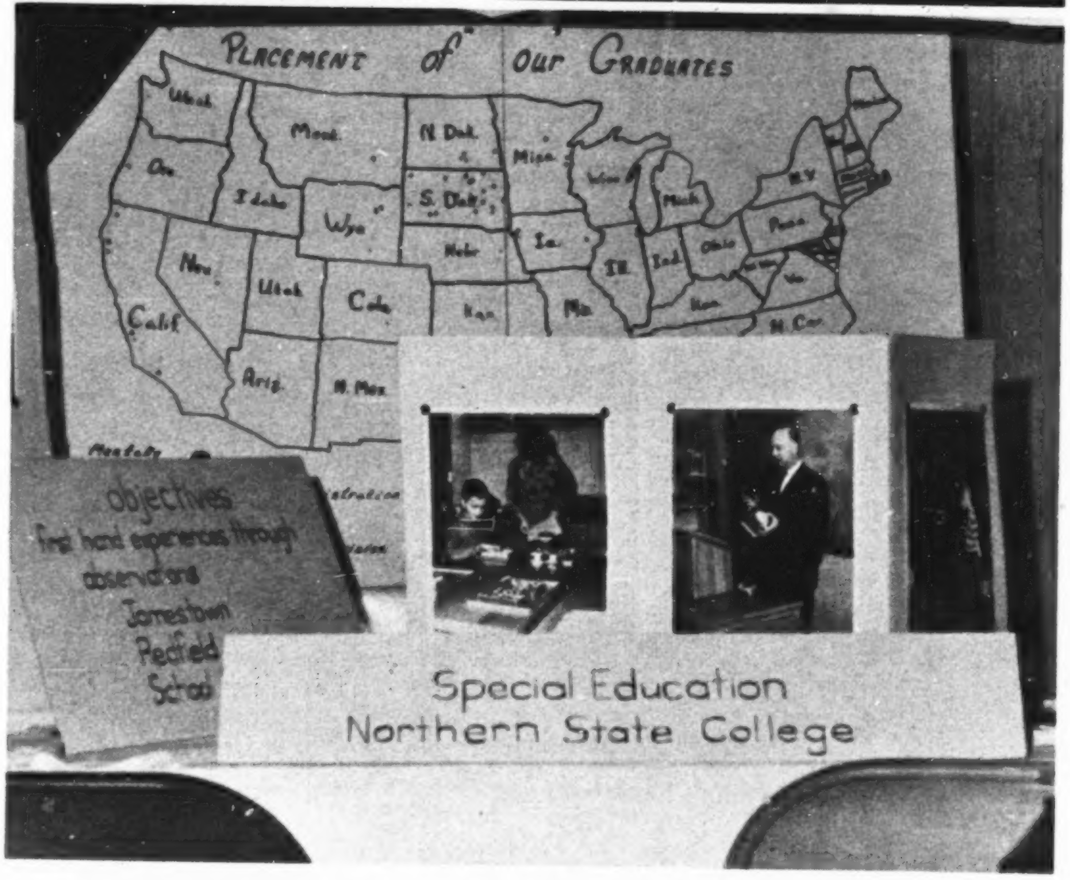
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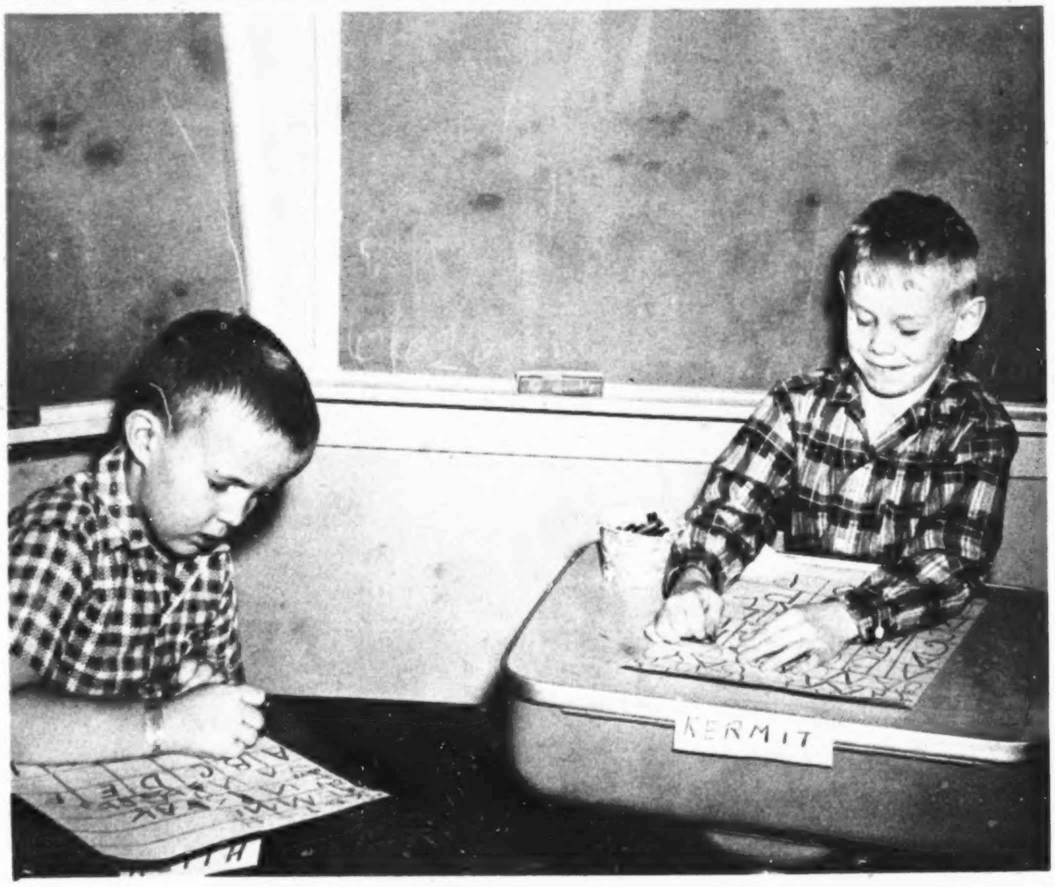
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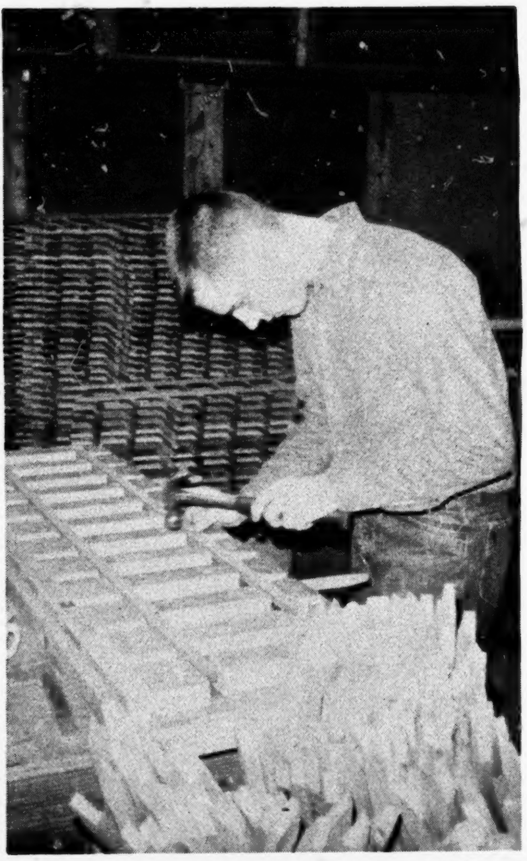

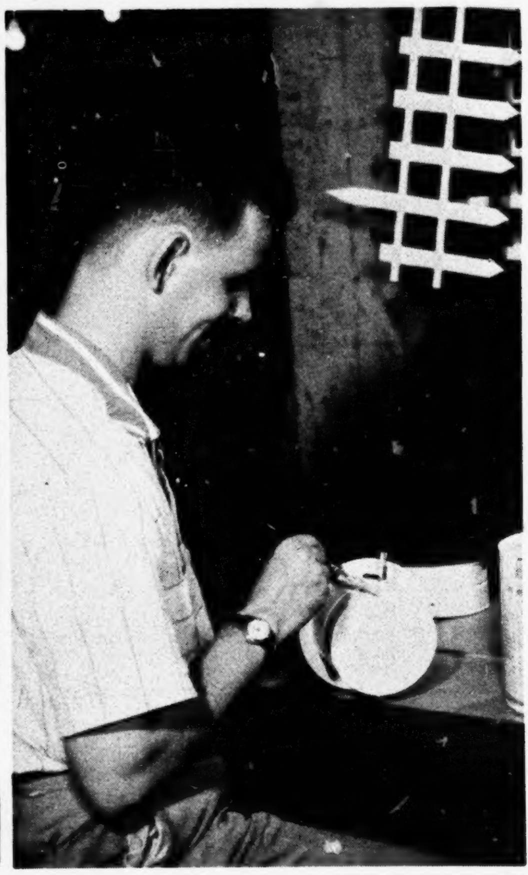

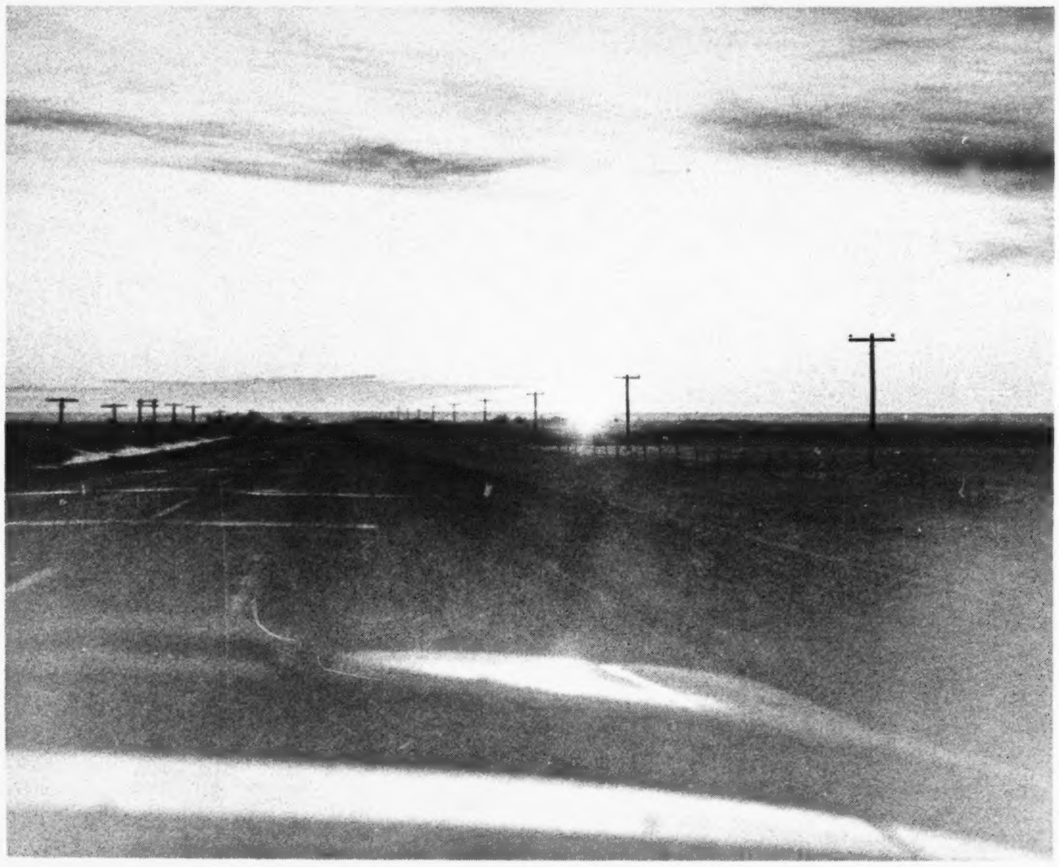

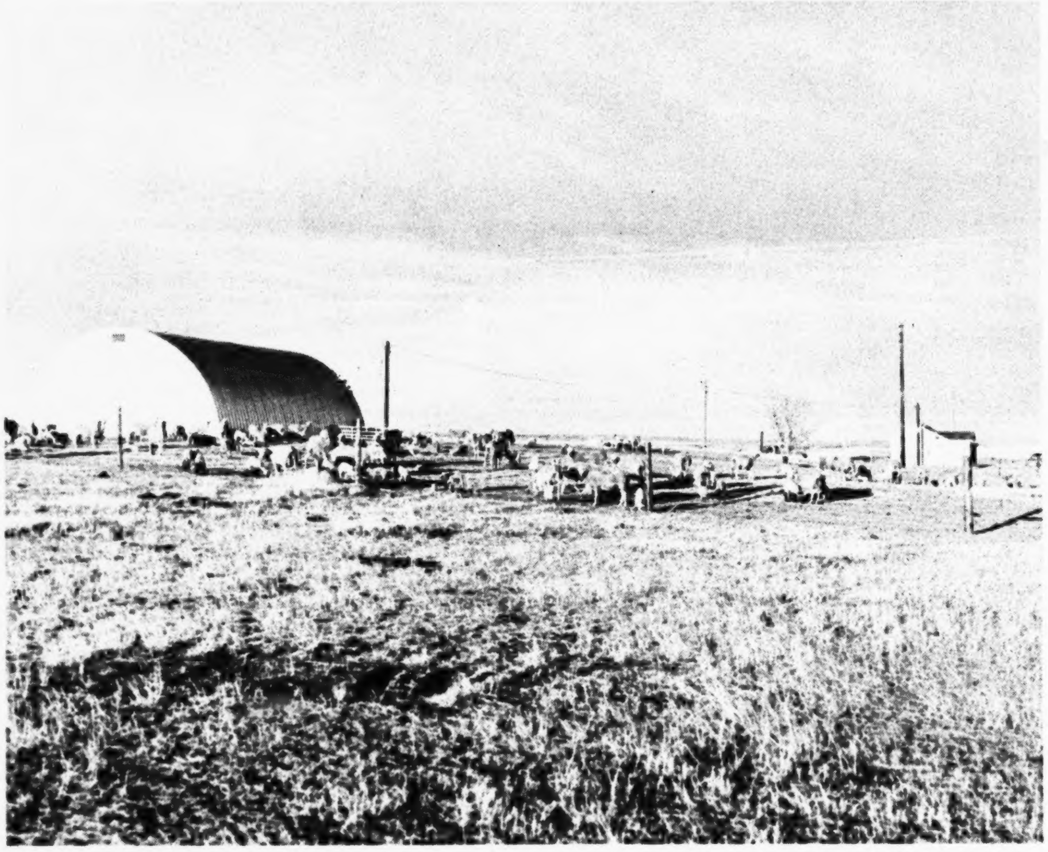

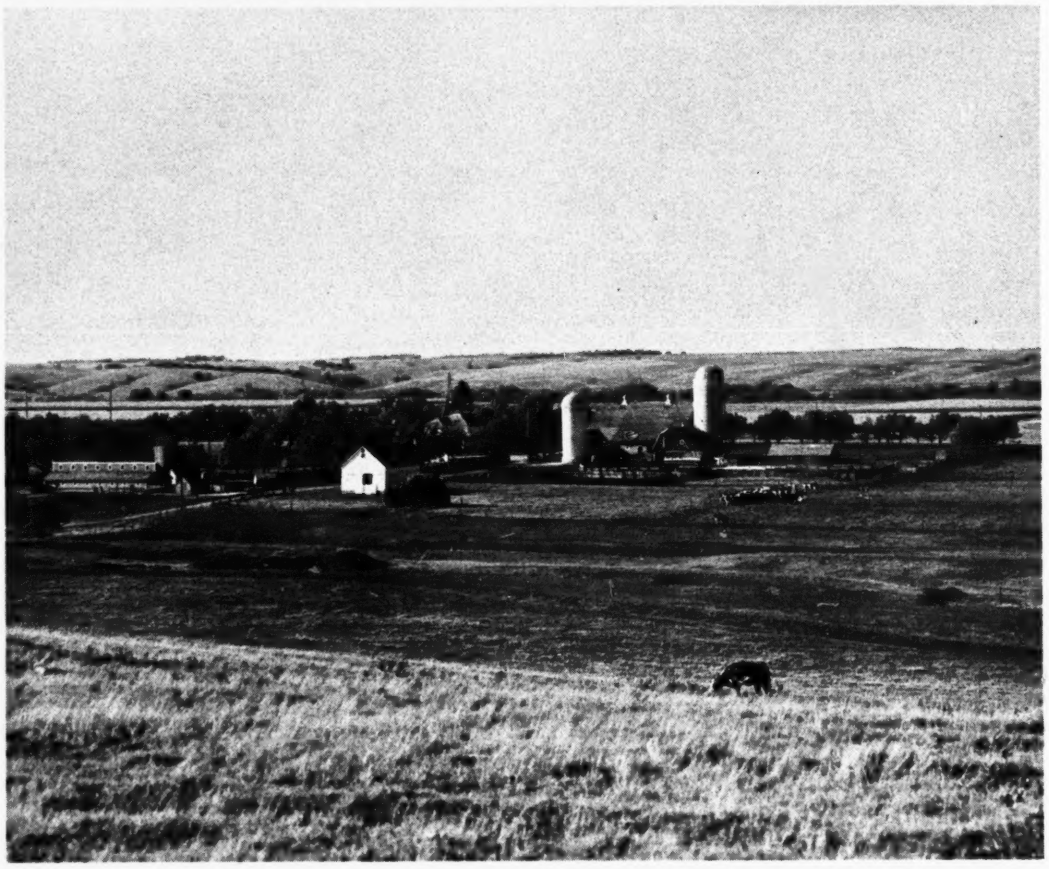

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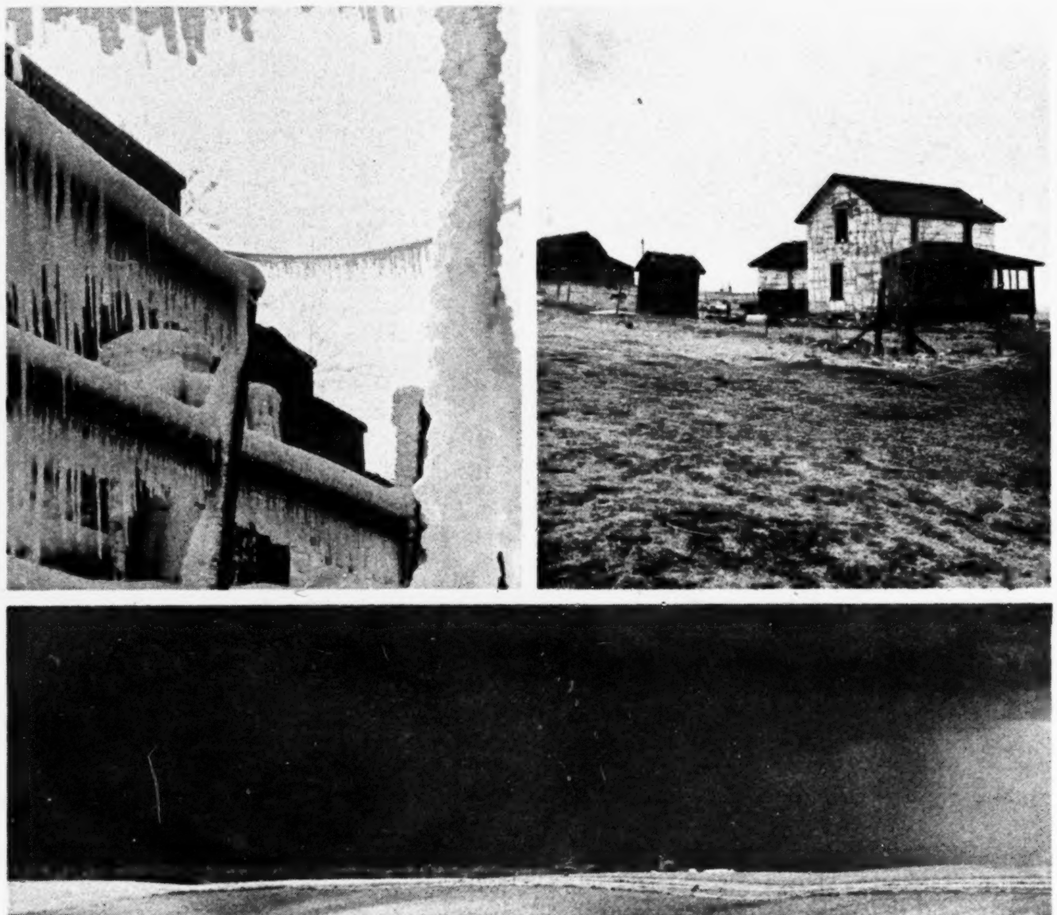

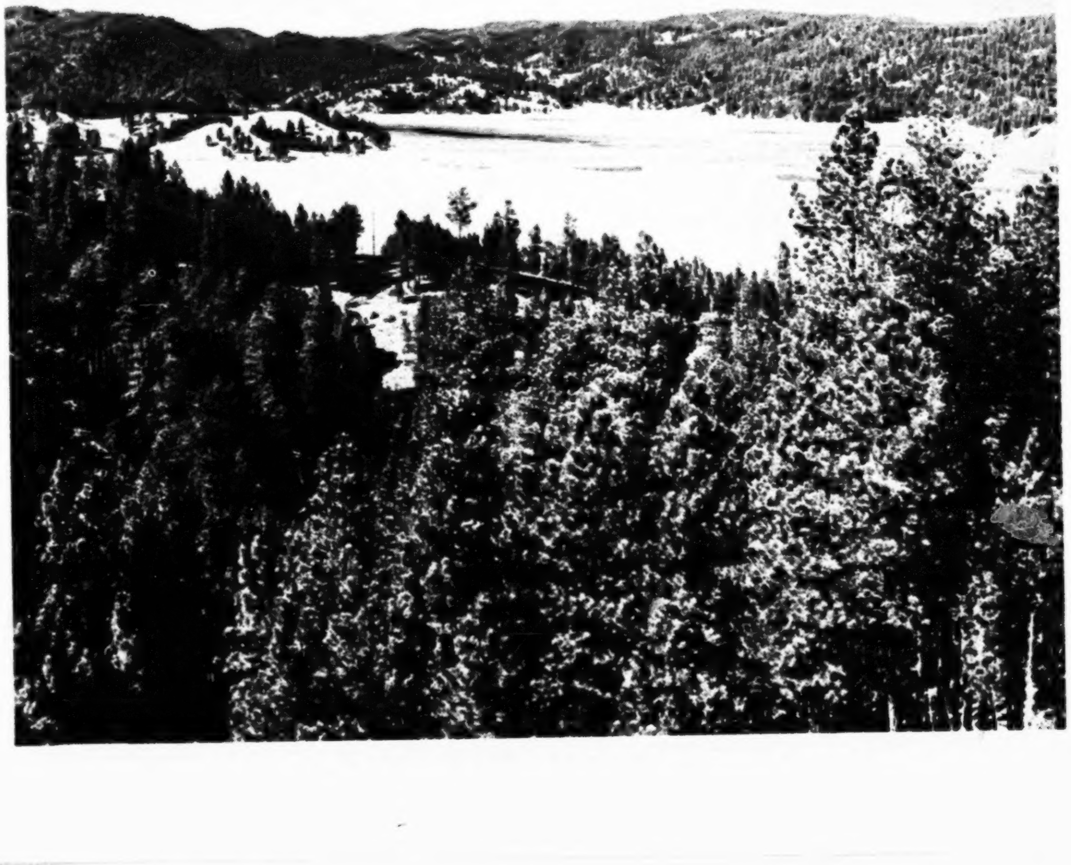

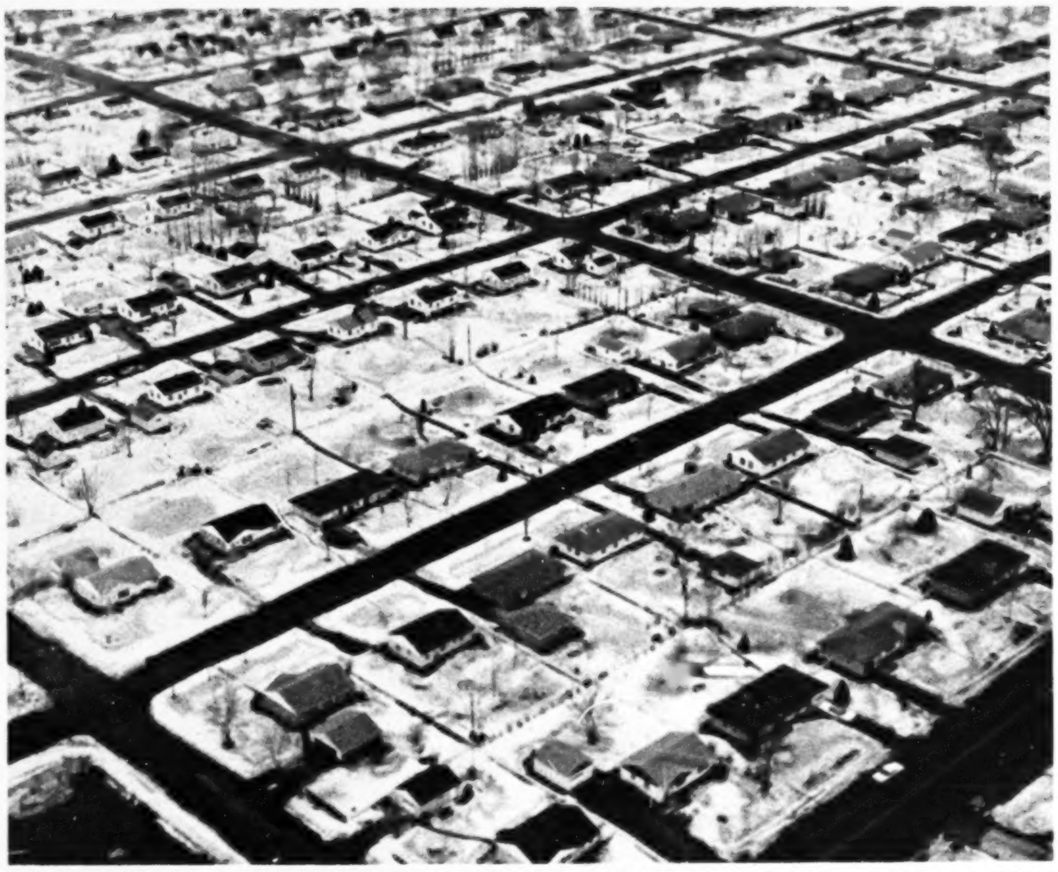

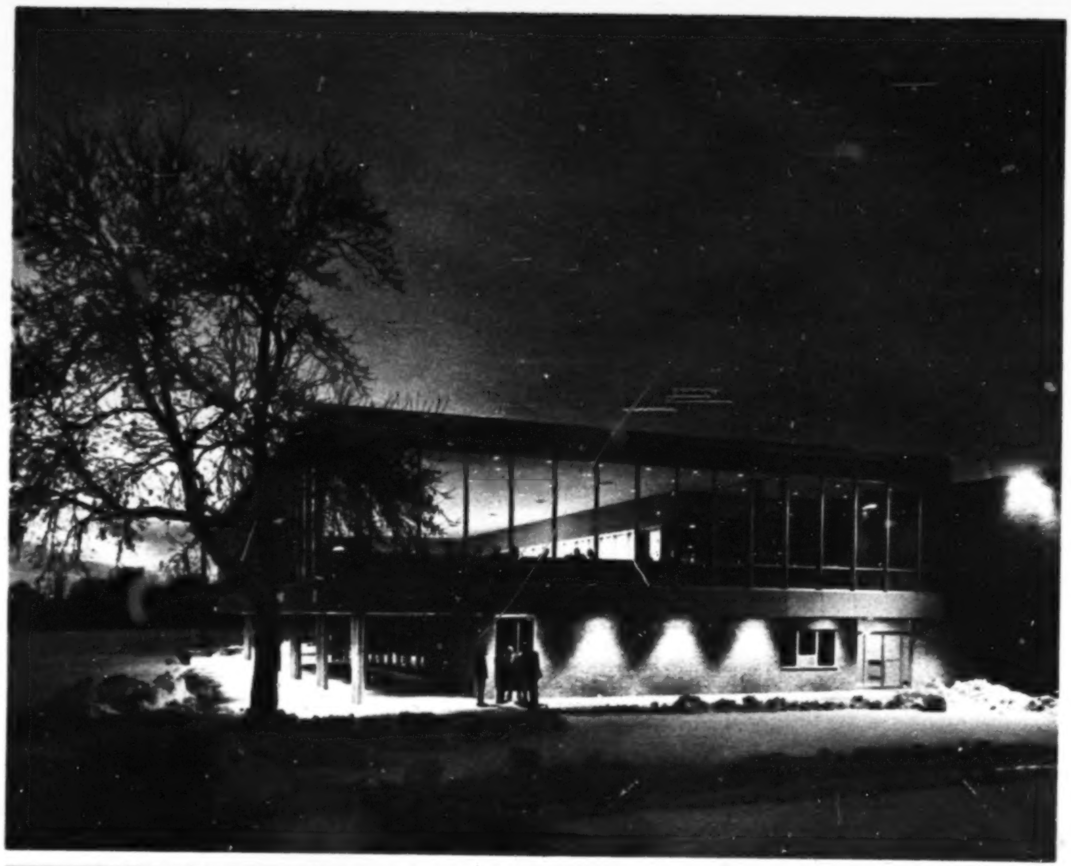

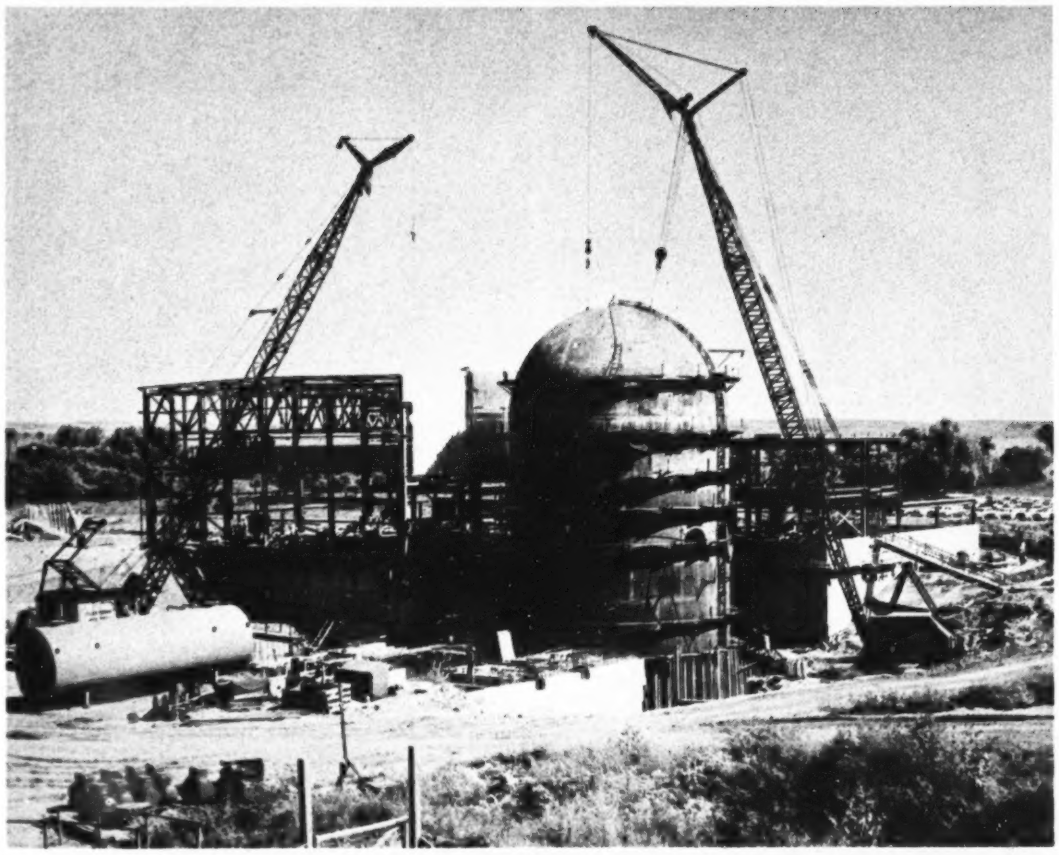

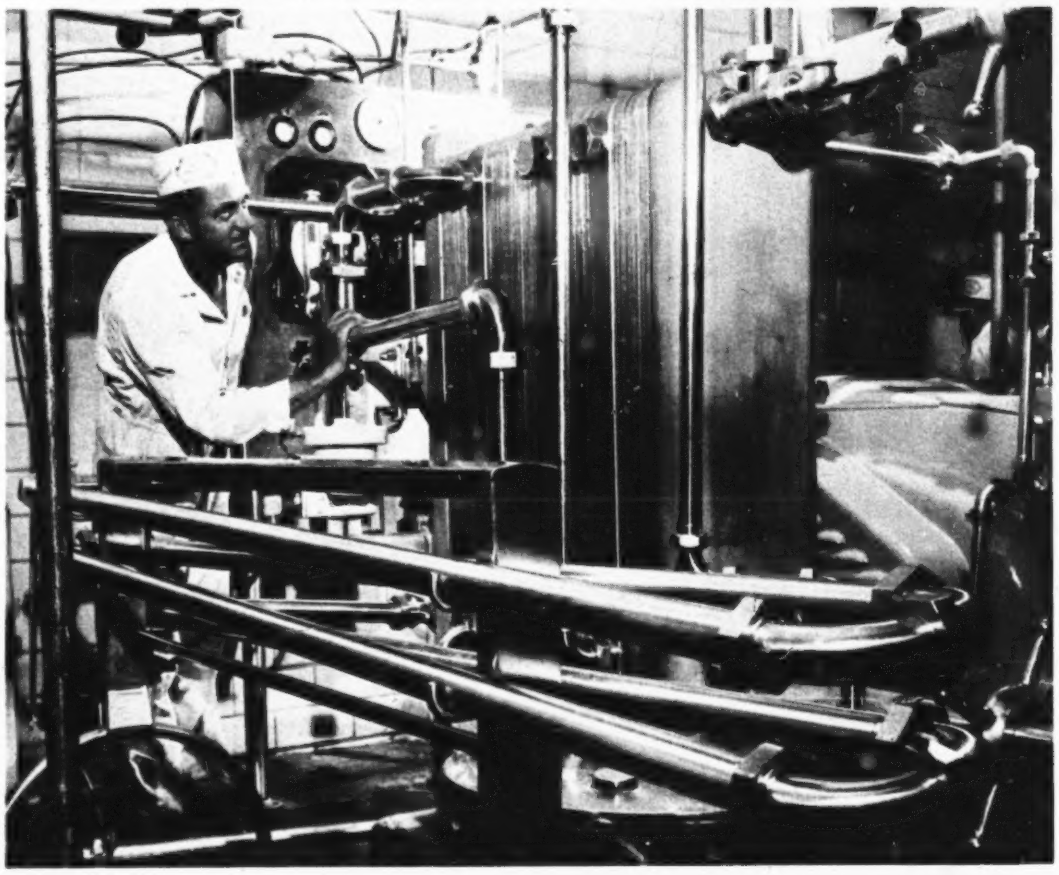

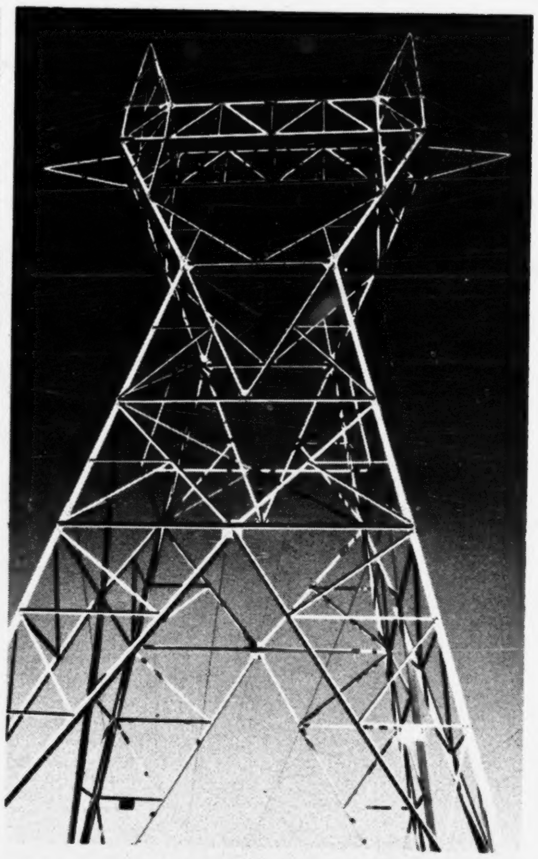

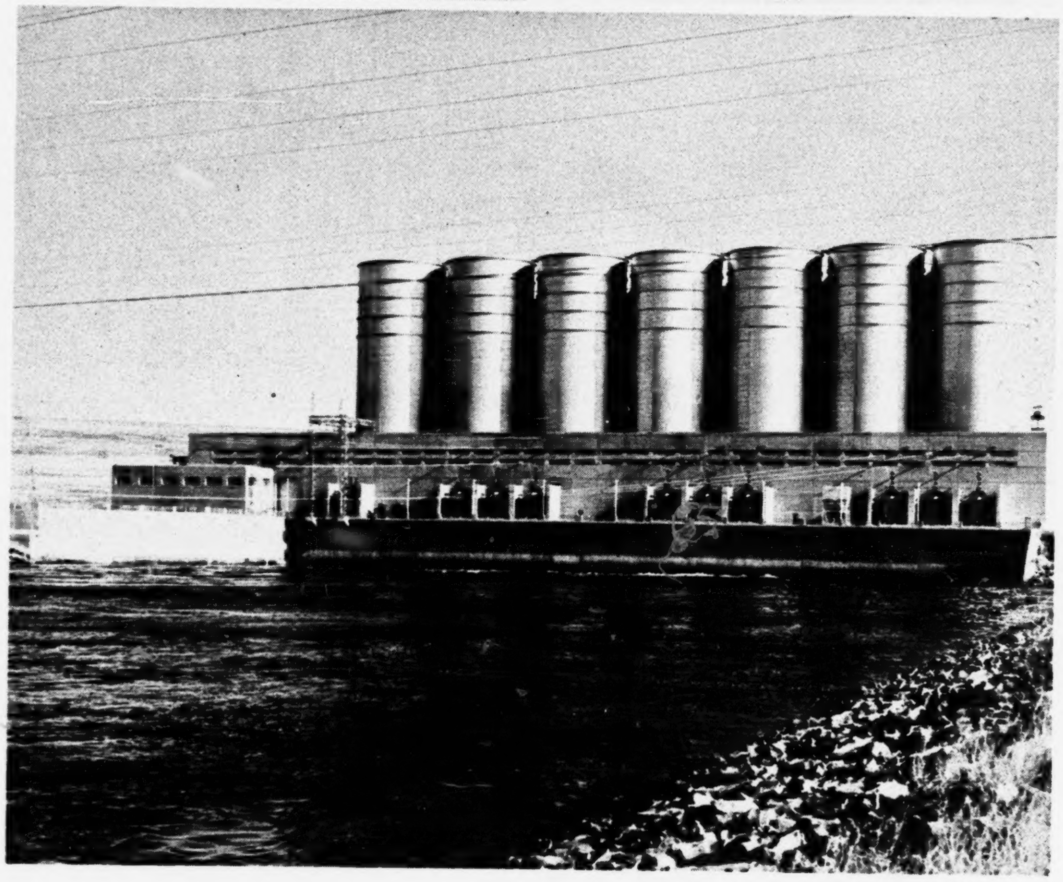

GERIATRICS

The care, treatment, and programming for the aging retarded person has drawn very little attention in the past. Frequently the reason for this lack of attention is the fact that in the past fewer retarded persons reached the advanced age than is true today. Medical advancement in care of secondary physical conditions often accompanying retardation is rapidly increasing and is likely to continue to increase even more drastically the number of persons reaching advanced years. While the advantages of longer life and better physical health for more years is a goal anxiously sought, planning for better use of the improved health and added years must be achieved if they are to be enjoyed and lived to the fullest benefit.

The retarded person may for purposes of care and treatment reach the condition of "declining years" at a much earlier age than would normally be expected. Physical limitations and mental deterioration may have an onset at what might be the prime of life for the person with better mental capabilities. The retarded person who has been trained to perform some task with his hands, or who has been trained in an occupation that requires standing or walking, may be too handicapped to be retrained for another means of employment in his twenties or thirties if he sustains an injury or deterioration of his physical capabilities. If he cannot be retrained for another job, he may even be incapacitated because of a change in the particular methods of production used by his employer. For these reasons, **planning for the geriatric retarded person should not be restricted to any particular age grouping.**

Identification of retarded persons in special care situations was attempted, using the criteria above. Contact was made with all special hospitals, general hospitals, nursing homes, and homes for the aged, asking identification of the retarded persons, the degree of retardation, the type of programming available, and an evaluation of whether or not the programming for the retarded peron was adequately meeting his needs. The conclusion can be drawn that most identified aged retarded persons are institutionalized at Redfield State Hospital and School. Only five identifications were made in general hospitals, 24 in the Yankton State Hospital, 14 in nursing homes, and 11 in homes for the aged. Because most nursing homes and homes for the aged indicated that they would accept retarded persons who could fit into their programs, **it is recommended that more extensive use be made of those facilities as a means of care and treatment when appropriate for the needs of the individual under consideration.**

The State Department of Health, the South Dakota Hospital Association, the South Dakota Nursing Home Association, and the South Dakota Association for Retarded Children should work cooperatively to encourage the establishment of programming in the nursing homes interested in providing care which will adequately meet the needs of the retarded who are likely to be so placed for care.

The services of the Department of Public Welfare are available under present programs to provide for placement and financial assistance required to meet the basic minimum costs of placement in nursing homes. **It is recommended that provisions be made to expand the use of nursing homes for the aged retarded whenever possible, rather than to encourage further placement in the institution.** Reasons for utilizing other facilities are covered in the section of this plan dealing with Dependent Living.

Many retarded persons are now eligible for benefits under Social Security. To be eligible for such benefits, the disabled retarded person must be the child of a parent who has worked in employment covered by Social Security and who has retired, died, or has himself become disabled. Disability under the Social Security law means "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long continued and indefinite duration." This means that a person classified as disabled is unable to do any substantial gainful work because of an impairment which can be found by doctors, and which cannot in the foreseeable future be so diminished by treatment that he can do substantial gainful work.

It should be pointed out that quite often the parents of a seriously retarded child will continue to work long after their child reaches 18 years of age. In such cases the child cannot become eligible to receive payments before one of his parents applies for retirement or disability benefits, or until a parent who has worked under the Social Security law dies. The mother of the disabled child beneficiary may also be eligible for monthly payments for as long as the child is in her care, regardless of her own age or her child's age. Payments are also made if the adult beneficiary disabled in childhood is in an institution.

Children under 18 may be eligible for benefits when a parent who has worked in employment covered by Social Security retires, dies, or becomes disabled. Benefits for a child who is not disabled will stop when the child reaches 18. If a seriously retarded child under 18 is already receiving child's benefits, the Social Security Office should be informed about his condition at least three months before he reaches 18. If it is determined that the child is disabled within the meaning of the Social Security law, his benefits can be continued when he reaches 18 without any interruption. The person 18 or over who has only slight mental retardation and can do gainful work is not eligible for Social Security disability benefits. In a family receiving Social Security survivor's insurance benefits because of the death of a covered worker, a child or an adult disabled in childhood generally receives 75 per cent of the amount the worker would have received at retirement. In a family receiving monthly Social Security retirement or disability benefits, the amount received by this type of beneficiary is 50 per cent of the worker's benefit. However, the total amount payable on the worker's account cannot, in any case, exceed the family maximum established by law.

Because of the many persons now covered under Social Security, and the possibility of financial assistance available to cover some of the costs of care or institutionalization, the foregoing is presented to emphasize the scope of the coverage. It is recommended that future planning groups and private organizations interested in the retarded offer Social Security information to parents of retarded persons and to nursing homes and homes for the aged who may find application of the benefits to be available for the welfare of the retarded.

It is recommended that Board of Charities and Corrections arrange for the employment of staff to investigate the possible benefits to be obtained for institutionalized persons.

DEPENDENT LIVING

Surveys have been completed of all of the facilities in the state in which retarded persons are or might presumably be located. The results of these surveys are as follows:

Redfield State Hospital and School	1190
Custer State Hospital	106
Yankton State Hospital	14
South Dakota School for the Deaf	0
South Dakota School for the Blind	10
South Dakota State Penitentiary	60
State Training School, Plankinton	0
State Welfare Foster Care	102
Indian Boarding Schools:	
Federal	31
Private Parochial	22
Crippled Children's Hospital and School	10
Privately Operated Boarding Facilities	26
Nursing Homes—under public welfare	45
Nursing Homes—private	30
Total	1646

An additional 976 are enrolled in special education facilities.

REDFIELD AND CUSTER STATE HOSPITALS & SCHOOL

It is felt that the administration and staff at the Redfield and Custer institutions are performing an excellent service to the mentally retarded of the state. We feel that limitations on their ability to perform to a higher level have been imposed because of the inadequacy of appropriations to upgrade services that are now known to be needed by retarded persons.

The major recommendations for the Redfield State Hospital and School and the Custer State Hospital are:

1. **Increased staff and upgraded salary scale at both institutions.**
2. **Construction of an Activities Building at Redfield State Hospital and School.**
3. **Expansion of facilities at Custer State Hospital to be in keeping with institutional population growth; and adaptations in existing facilities at Redfield.**

1. INCREASED STAFF AND UPGRADED SALARY SCALE

The AAMD recommendations pertaining to institutions are an indication of the way in which the personnel ratio should go; Redfield State Hospital and School and Custer State Hospital should have sufficient funds to approach the AAMD standards and national public institutions averages.

The present employee-patient ratios and expenditures at Redfield and Custer, as compared with the national average are:

TOTAL EMPLOYEE-PATIENT RATIOS

[1]Entire South Dakota	1 to 4
[2]Entire United States	1 to 2
South Dakota Percentage of National Average	50%

ATTENDANT EMPLOYEE-PATIENT RATIOS

Total Attendants	1 to 7½
Average Attendants Per Shift	1 to 30
AAMD Recommendations	1 to 2½

DAILY EXPENDITURE PER PATIENTS UNDER TREATMENT

[1]Entire South Dakota	2.95
[2]Entire United States	5.50
South Dakota Percentage of National Average	53.6%

Based on a combined institutional population (Redfield State Hospital and School and Custer State Hospital) of 1,280 residents, the following is a table of present (September 1, 1965) and recommended personnel, based on standards recommended in the Monograph Supplement to AMERICAN JOURNAL of MENTAL DEFICIENCY, January, 1964, Volume 68, No. 4, "Standards for State Residential Institutions for the Mentally Retarded".

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[1] Includes Redfield State Hospital and School and Custer State Hospital. A listing of present staff at Redfield and Custer is attached.

[2] Mental Health Statistics "Current Reports" U.S. Department of Health, Education and Welfare. Fiscal year ending 6-30-64. Forty-nine states (Nevada has no institution for the mentally retarded) plus the District of Columbia, reported. Only one state (Mississippi) spent less per patient under treatment than South Dakota.

	Approximate AAMD RECOMMENDATIONS	RSHS & CSH	Approximate additional funds required to meet recommendations	
Physician	6	3¼	$ 35,000	
Registered Nurse	64	5	236,000	
Dentist	2	1/5	10,000	(1)
Pharmacist	1	0	6,000	
Speech and Hearing	3	0	20,000	
Chaplain	3	0	7,000	(1)
Social Worker	14	0	15,000	(2)
Psychologist	6	1	8,000	(1)
Recreation	7	3	6,500	(1)
Dietary Services	Excess of 100	33	158,000*	
Attendants	500	206	617,400*	

*These figures are based on the wage that it is presently possible to pay; this should, however, be increased to a comparable living wage.

Other professional and training personnel, such as teachers, physical and occupational therapists, vocational consultants, beauty operators, barbers, volunteer coordinators, as well as various administrative, maintenance and service personnel, are staffed at a ratio from 0 to ½ the recommended standard.

An expanded employee working force would lessen the reliance and dependence on resident labor which tends to reduce effectiveness of the training program through inflexibility of patient training assignments. This dependency on the productivity of the resident does not stop, but complicates the community placement program. It is estimated that residents perform almost half of the work load of the institution and the average pay per working resident since the increased appropriation in the 1965-66 fiscal year is approximately $4.00 per month. There are approximately 500 classified as working residents. **It appears that a gross injustice is being done to residents who, because of lack of community facilities are called upon to carry out a full work load throughout their lives while receiving only token payment in addition to board and room. It is recommended that adequate appropriations be made to increase the patient pay scale to a level in keeping with their performances. It is further recommended that adequate staff be employed to make it possible to release patients who are capable of adjusting to living outside the institution.**

The crux of the problem is that of the salary scale available to personnel, particularly in the classifications such as attendants. The beginning salary is $190.00 per month. Beginning salaries for this category in other states exceed this amount by $50.00 to $150.00 more per month. For example, at the State Institution in Grafton, North Dakota, the attendant starts at $175.00, but after a brief trial period his salary is raised to $250.00 per month. Top attendants with many years of service at Redfield State Hospital and School in 1965 were for the first time paid $250.00 per month. The starting wage that it is presently possible to pay dietary personnel is $190.00 per month. This should be increased to a comparable living wage.

One should keep in mind that the staff required are specialists and in order to compete, something must be added to the going salary as compensation for the handicap of the rural location of the institution.

Increased state appropriations are necessary in order to make it possible to alleviate these present problems.

2. ACTIVITIES BUILDING AT REDFIELD

The Activities Building for habilitation with the final goal of community placement should include: swimming pool, bowling alley, occupational therapy unit, canteen, beauty shop, barber shop, game rooms, gymnasium (with some limited spectator seating accommodations and multi-purpose floor for dancing, indoor sports, roller skating, games, etc.). The Activities Building should be designed to provide services normally provided in a community.

Space should be provided for an occupational therapy program in order for the patients to learn skills and habits which would make them more adaptable to life outside the institution. Community placements would help to free other space which could and should be converted to extend and improve available services, administrative and professional services.

The Center would lend itself toward enhancing physical activity of the individual (lack of patient activity creates mental lethargy), keeping in mind that the present community opportunities for the institutionalized patient are limited by the shortage of resources at the disposal of the staff.

This is just a part of the total philosophy and total program geared towards habilitation and training, rather than custodial care which still to a large part must be provided. These are necessary services to that goal for which the Redfield State Hospital and School is aiming.

The estimated cost of such a center is $650,000.00.

3. EXPANSION OF FACILITIES AT CUSTER STATE HOSPITAL AND ADAPTATION OF EXISTING FACILITIES AT REDFIELD

A renovation of existing first floor facilities at Custer State Hospital should be undertaken, along with additional staffing, to attain maximum use of the existing facilities, and a long range program of renovation and building to absorb the population growth of institutionalized retarded in the state, keeping in mind that all resources from AAMD and NARC (professional and lay) agree that institutions should not be any larger than Redfield is presently, and ideally could be smaller.

Changes in existing facilities at Redfield: Most of the existing buildings were designed as a product of an era emphasizing isolation from society and custodial care with a minimum of expense. They are designed unrealistically, and should attempt to duplicate a home-like environment so that the difference between institutionalization and community life is not so great that adjustment in the process of coming and going becomes impossible. **The wards are presently so large that privacy is impossible.** Each person should be allowed to develop individual skills, pursue individual interests. Privacy is needed to allow for individual thinking to be geared to something other than continual group living. Even the casual observer on a ward can realize that just the accoustical affect alone is a detriment even for those receiving just custodial care. Even those who are in a very dependent status need some privacy and the "interaction" of the group is probably even more damaging to the stability of the individual. Privacy is not a need just of the more capable, but definitely a need for those of lower mentality, in some instances to a much greater degree in order that they may learn normal social traits.

OTHER RESOURCES

The fact that the South Dakota School for the Deaf does not accept students who are mentally retarded and have limited hearing ability, coupled with the absence of any trained speech and hearing personnel at Redfield State Hospital and School, indicates a gap in service for those individuals, and emphasizes the fact that a primary need of the Redfield facility should be to provide a program to fit the needs of mentally retarded children having hearing problems. The employment of qualified personnel to handle this type of problem would seem logical rather than to insist that a program for the child with limited learning ability be instigated at the School for the Deaf, inasmuch as the number might be rather small and require staff which would not otherwise fit into the program at the School for the Deaf. Staff employed at Redfield for the training of mentally retarded persons with hearing problems could also, on the other hand, be put to economically feasible use with other individuals having related problems, i.e., speech and language problems. **It is recommended,** however, **that** the interpretation of "those mentally and physically able to benefit from an educational program" under which **the School for the Deaf** operates be expanded to **include the mildly retarded, even if a special class is needed.** Such a service could be included in the facilities of the School for the Deaf. The estimated number of persons in the state having the dual handicaps of mental retardation and hearing loss is 43.

It will also be noted that the South Dakota School for the Blind does have some individuals who are classified as mentally retarded. It is the feeling that due to the nature of the learning problems of the blind, they are properly placed and **instead of initiating a new expensive program for the blind at Redfield, the School for the Blind be encouraged to extend their services to include those retarded persons having vision losses who would, through training, be able to benefit from a program designed to meet their needs.** The estimated number of persons in the state having the dual handicaps of vision loss and mental retardation is 36.

Some provisions should be made at Redfield State Hospital and School or at Custer State Hospital to provide for individual care required for the more severely retarded blind persons. Occupational therapy services should be available to alleviate the severity of the handicapping condition insofar as possible. An acceptable alternative or supplemental means of aiding to fill the gap in services would be to make nursing care service in nursing homes available to the blind retarded who would not likely benefit from training because of age or degree of handicap.

The staff of the South Dakota State Penitentiary recognizes that the comparatively high percentage of inmates classified as mentally retarded may be inaccurate due to the testing problems on intake. The staff also recognizes that testing at a later time might yield a substantially smaller number and that more adequate testing should be done. **Those inmates who show possible retardation should be thoroughly evaluated.** Proper retraining plans should be made accordingly. The most logical solution to the problem will probably be found in providing more adequate programming for the retarded and near retarded in communities, before they are involved in criminal acts.

No retarded persons are maintained at the State Training School. The policy there is that when a person is classified as mentally retarded, he is placed on the waiting list for the institution at Redfield. **Evaluative services should be extended at the State Training School.**

The federally provided boarding schools for Indian children have indicated only a small number of mentally retarded students (31) being served by these facilities. Diagnostic evaluations carried on by the project of the University of South Dakota indicates the presence of a considerable number of children who, according to the screening tests have needs which should be considered for special education. The needs are recognized by the Area Office supervisory staffs. The extremely complex problems in coping with the entire educational and environmental Indian Reservation situation makes the reaching of a solution to one of the special problems a long process. **Indian education needs general reevaluation before special programming can be logically planned.** Attacks on the conditions are being considered by the Congress of the United States and by the Department of Interior and other Federal agencies through various programs at the present time.

Private parochial schools which are operated for the benefit of Indian children indicates a small number (22) of retarded which are included with other children. No special education classes or other services for the retarded are offered by any of the parochial schools. The general policy in these units is not to attempt to offer special services. No further service should be expected of private parochial schools. The services they are providing are needed.

The relatively high percentage of Indian patients at both Custer and Redfield institutions indicates several influencing factors. Among these would appear to be: living conditions of the Indian families prevent caring for retarded persons in their homes; lack of available special services on or near the reservations, lack of understanding of how to care for the retarded in the Indian economy, etc.

The Crippled Children's Hospital and School is a private organization designed to serve the educable orthopedically handicapped child. Ten children who are classified as retarded as well as physically handicapped are currently enrolled in the program. If the projections of need for this facility indicate the likelihood of available space for an expanded program within the existing facility, the establishment of a policy of accepting more multiple handicapped children should be encouraged.

One of the privately operated facilities for sheltered workshops for adjustment training maintains a boarding arrangement for 26 young people. Other **sheltered workshops** located in Aberdeen, Mitchell, Sioux Falls, and until recently Huron, **have evidenced a need for some boarding facilities.** Standards for boarding facilities need to be developed. Various and perhaps cooperative plans for providing and operating such facilities should be encouraged.

The Division of Child Welfare has fifty-three retarded children placed in foster care under supervision. These arrangements appear to be very satisfactory, but the need for greatly expanded opportunity for placement in this type of situation exists. Problems which prevent the expanding of foster care are: shortage of staff, lack of available foster homes, and a lack of awareness on the part of the public, of this function of the Division of Child Welfare.

Private welfare agencies should be made aware of needed services.

The placement of retarded persons in nursing homes and homes for the aged by the Department of Public Welfare is an area which cannot at this time be properly evaluated. The number is small (45), and the reasons for the placement are for the most part unknown or unavailable. **The increased use of nursing homes and homes for the aged on the part of public welfare is one possible answer to the projected increased need of supervised care for those who might otherwise need institutionalization.**

If the problem of finding adequate foster homes or nursing care continues to exist, **local or regional boarding facilities must be planned.** Such units may be built using State, local governmental, or private non-profit funds for fifty per cent of the cost of construction, to be matched with a like amount of federal funds under Public Law 88-164. Such units should be planned to house and provide a continuum of care, training, rehabilitation, work training, counseling, etc., for a wide range of age and disability groups. The operational cost of maintaining such a facility will require a combination of resources. County funds similar to those county funds now used to pay the State General Fund for those residents of the institutions should be used first. Either Child Welfare or Public Welfare funds should be utilized for those qualifying under those programs. For the school age child, County special education tuition funds should be utilized for the payment of that part of cost concerned with education and training of the child. The cost of board and room for the child boarded away from home for school purposes may be assumed by the school district under arrangements now concerned with transportation of the child or board and room in lieu of transportation not to exceed $1.50 per day for days the child is boarded away from home for school purposes. Direct state subsidy may be needed to supplement the cost of maintenance.

The State Department of Health, Hospital Facilities Section, is charged with the responsibility of drawing up a set of priorities for the building of facilities under Public Law 88-164. Arrangements for an Advisory Committee to assist the Hospital Facilities Director in setting priorities was made by the 40th Legislature by the passage of Senate Bill 145. **It is recommended that** in keeping with the intent of Public Law 88-164 and the desire of the people of South Dakota, preference be given to the **construction of facilities which,** in the opinion of the Hospital Facilities Section and its Advisory Committee, **will provide** needed programming to the largest unserved section of the State and show evidence of arranging for **the most comprehensive program for the retarded** it is intended to serve. Priority should also be given to those applications which show evidence of supervision and participation by lay board representatives of community interest. If more applications are received than funds can be made available to match, priority should be given to those in which arrangements are made for phases of development which could be constructed and for which programming could be initiated before the completion of the remainder of the comprehensive unit. If fewer applications are received than would utilize the available federal matching funds from private non-profit sources, applications from State institutions should be given next priority. If no applications are received from either of these categories, arrangements should be made to assist programming in neighboring States which could be utilized by South Dakota persons.

Not only should there be encouragement of facilities designed to provide a comprehensive program, under one jursidiction, but also of groups which will provide some segment of service. For example, community or church-supported group living for young adults might serve to meet a need not otherwise being met. It should be made possible for County funds to be expended in support of such arrangements where that it would make the substitution of that type of managed living and/or working arrangement practical in lieu of institutionalization of the person. Such arrangements could very well provide much more acceptable programs for the retarded persons and could be offered at a considerable savings to the State as compared to the cost of lifetime institutionalization.

It is further recommended that boarding schools on a five-day week be encouraged in areas where persons are insufficient in number

to make the establishment of specialized classrooms feasible. These units could be variable in size, depending on the area to be served and the degree of specialty to be provided. Arrangements should be made so that several counties could share the cost of building and operating such facilities. If three special education facilities could be constructed in conjunction with other comprehensive units, to provide special education not available in close proximity to sparsely populated areas and to provide more specialized education to children whose problems cannot be adequately met in the existing school-provided special education classrooms, experience could be gained as to the needs, and these facilities could either be enlarged or additional units could be built in other areas. Such units should be constructed for a 100 student maximum capacity. Provisions for programming should include: nursery, diagnostic, preschool, primary, intermediate, junior high school, senior high school, and work training experience. Skilled teachers and therapists should be employed and psychological counseling and testing should be available as well as social case services. Medical supervision of the health needs should be available on a consultative basis. Vocational counseling and placement should be a vital part of the program.

PUBLIC AND PROFESSIONAL INFORMATION

Investigation through the county surveys and regional meetings of problems of public and professional information indicated that there is a lack of public understanding of what mental retardation is, the potential of many retarded persons to be helped, and confusion between mental retardation and mental illness. To some extent the lack of the same information exists among many professional persons. The reason for the lack of understanding of the mentally retarded and the problems and services needed is undoubtedly due to the relative newness of the knowledge that retardation is not usually a hopeless condition about which nothing can be done, and that it is not a reflection on the parents' morals and intelligence to have a retarded child. Even though considerable effort has been placed on publicizing new knowledge about ways in which most retarded persons can be helped to become useful citizens, it has not yet become an accepted fact by the general public.

Methods of changing public attitudes were considered and evaluated. It was determined that a combination of methods would be required in order to insure achieving of the goal of public understanding and acceptance of mentally retarded persons in the communities. Information supplied through public media with national distribution is a valuable resource of coverage, but it alone cannot be expected to be sufficient to change public attitudes toward a nearby problem. Local news media serves a purpose if the material supplied for use is deemed newsworthy enough to have reader appeal. It is recommended that persons interested in furthering public understanding of mental retardation should supply material which is highly localized and newsworthy to the local radio, television, and newspapers, and other club publications. Persons in charge of determining the selection of materials to be used should be recruited to assist in organizations interested in mental retardation. Libraries should be encouraged to obtain up-to-date publications of books and pamphlets on mental retardation. Displays of work accomplished by retarded persons should be made at local fairs, farm shows, etc., where informational pamphlets may be distributed and conversation held with interested persons. Speakers should be made available on each local level to give information to public meetings such as PTA's, service clubs, veterans' organizations, and school classes. Local leaders of communities should be asked to join in efforts to inform the citizenry of all the needs of the retarded. Parents of retarded children should be encouraged to tell about their problems and ways of overcoming them. Public meetings using both local persons and outside speakers will add to public understanding. Distribution of the state plan for mental retardation and summaries of the recommendations should be widely circulated. Future planning activities should include the development of informational films and pamphlets for public information. Conversation on a one-to-one basis is undoubtedly the most effective way of changing public attitudes, but unfortunately is slow in reaching vast numbers of persons particularly in a predominantely rural population such as is present in South Dakota.

Materials dealing with facts about mental retardation should be developed and distributed by the Health Education Division of the State Department of Health for use in health education classes in high schools and junior high schools. Such material should include information about prevention of mental retardation, and the value of good prenatal care. It is essential that attitudes of understanding of mental retardation be created early in a person's life.

More factual information about mental retardation needs to be presented to persons who occasionally come in contact with retarded persons and their families in their professional capacity, such as judges, county commissioners, clergymen, teachers, and labor leaders. It is recommended that the future planning authority within the state utilize the publications identified as most frequently used by these and other professional persons as the means of continuing to inform them about mental retardation.

RESEARCH AND STATISTICS

Consideration is given in this report to statistical information; to the means of obtaining information related to carrying out all service tasks effectively; and to the advisability of certain types of basic research into the causes and conditions of retardation.

A major problem encountered was in determining a working definition of mental retardation. The following definition, as proposed by the American Association on Mental Deficiency (AAMD), is accepted:

> "Mental Retardation refers to sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior."

Because of the lack of adequate records as well as the lack of services and facilities, only an estimate can be given to the number of mentally retarded persons in South Dakota. The President's Panel on Mental Retardation proposed that 3% of the total population might be considered to be retarded. It is felt that this figure may be somewhat high for South Dakota. County planning committees in Brookings and Codington counties made studies on the number of mentally retarded in their respective counties. Brookings County estimated that 1.79% of the total population was known or suspected to be mentally retarded. The Brookings County Committee mailed questionnaires to professional and other interested individuals. The total number of 170 mentally retarded individuals reported reflects both identified and suspected cases.

Codington County studied the age group 6-16 and estimated that 2.95% of this group was known or suspected to be mentally retarded. This study again, reflects both identified and suspected cases. There were 67 confirmed cases reported in Codington County and, as reported by school officials, 68 suspected cases. The total of 135 cases of confirmed and suspected mental retardation would be 2.95% of the total enrollment, 4,581, of all elementary and junior high schools.

An estimate of 1.58% as mentally retarded among children in kindergarten through ninth grade was made for the city of Sioux Falls. This estimate was based on data compiled by the Division of Pupil Personnel Services of the Sioux Falls Public School system. The students attending parochial schools were not included in the total enrollment figure. It was noted that the parochial schools do not offer special education classes for exceptional children. This percentage of mentally retarded in grades K-9 would apply to an age group 5-14 years. An estimate of 30 mentally retarded in grades K-9 was added to 199 identified and confirmed cases, arriving at a figure of 229 cases. This would be 1.58% of the total enrollment in the K-9 grades of 14,500.

Using figures obtained by Mrs. Dorthy Crawford for use in her thesis, "A History of Special Education for the Mentally Retarded in South Dakota", in which the 1.4% Selective Service rejection rate in South Dakota for Mental Deficiency in World War II was applied to the 1960 population figures for each county, the total of these retarded persons would be 9,528.

In California, the Study Commission on Mental Retardation concluded that different age groups would have different percentages of retarded. The figures proposed by the California Study Commission are as follows:

Under 5 Years of of Age	0.5%
5-7	2.2%
8-16	3.0%
17-54	2.0%
55-59	1.5%
60-69	1.0%
70-Plus	0.5%

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN SOUTH DAKOTA

Based on 3% of the Total Population

	State Population	Estimated Mentally Retarded
1960[1]	680,514	20,415
1970[2]	700,953	21,029
1980[2]	751,233	22,537

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[1] 1960 Census figures.

[2] Population estimates from State Department of Health Division of Public Health Statistics.

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN SOUTH DAKOTA

Based on California Study adjusted to South Dakota
Age Group Estimates

Ages	Per Cent	State Population			Estimated Mentally Retarded		
		1960	1970	1980	1960	1970	1980
Under 5	0.5	83,127	76,473	92,609	416	382	463
5-9	2.2	77,911	73,350	80,774	1,714	1,614	1,777
10-19	3.0	119,509	141,644	133,109	3,585	4,249	3,993
20-54	2.0	268,406	264,453	283,185	5,386	5,289	5,664
55-59	1.5	31,220	33,509	35,335	468	503	530
60-69	1.0	54,919	55,386	61,227	549	554	612
70 & over	0.5	45,422	56,138	64,994	227	281	325
TOTAL		680,514[1]	700,953[2]	751,233[2]	12,327	12,872	13,364
Per Cent of Total Population					1.81%	1.84%	1.78%

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN SOUTH DAKOTA

Based on California Study modified by using Codington County data
for certain ages and then adjusted to South Dakota
age group estimates

Ages	Per Cent	State Population 1960	Estimated Mentally Retarded 1960
Under 5	0.5	83,127	416
5-14	2.95	145,355	4,288
15-19	3.0	52,065	1,562
20-54	2.0	268,406	5,368
55-59	1.5	31,220	468
60-69	1.0	54,919	549
70 & over	0.5	45,422	227
TOTAL	1.89	680,514	12,878

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN SOUTH DAKOTA

Based on Brookings County Estimate of 1.79% of Total Population

	State Population	Estimated Mentally Retarded
1960	680,514	12,181
1970	700,953	12,547
1980	751,233	13,447

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[1] 1960 Census figures.

[2] Population estimates from State Department of Health Division of Public Health Statistics.

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN SOUTH DAKOTA

Based on California Study modified by using Sioux Falls data for certain ages and then adjusted to South Dakota age group estimates

Ages	Per Cent	State Population 1960	Estimated Mentally Retarded 1960
Under 5	0.5	83,127	416
5-14	1.58	145,355	2,297
15-19	3.0	52,065	1,562
20-54	2.0	268,406	5,368
55-59	1.5	31,220	468
60-69	1.0	54,919	549
70 & over	0.5	45,422	227
TOTAL	1.6	680,514	10,887

It is recommended that continued efforts be made in future planning projects to obtain more accurate estimates of the number of mentally retarded persons in South Dakota.

The records located at Redfield State Hospital and School are the main source of information on the mentally retarded in South Dakota. **It is recommended that the central system for reporting the mentally retarded should be the State Commission for the Mentally Retarded.** A small permanent staff appointed by the State Commission should be located at Redfield. This staff should have the functions of record collection and tabulation of data for research purposes.

Pilot studies on mental retardation should be instigated in South Dakota. Various types of studies could be carried out in this state much easier than in many other areas of the nation. Suggested studies are: Follow-back studies on individuals with reported congenital malformations; socio-economic studies of selected areas of the state; various studies based on records maintained at Redfield State Hospital and School; and studies based on students in special education classes in the public school sytems throughout the state.

Congenital malformations reported by physicians on birth certificates sent to the State Department of Health, Division of Public Health Statistics, indicate a need for consistent reporting and a need for uniform terminology. Before the congenital malformation item in the medical and health portion of the birth certificate can have a valid statistical use in future research, there must be improved reporting on malformations.

It is recommended that physicians in the state meet periodically to study the reporting of congenital malformations. It is possible that such meetings could be arranged through the cooperation of the South Dakota State Medical Association and the Division of Public Health Statistics of the State Department of Health. It is suggested that physicians should be informed of the importance of being more specific in reporting congenital malformations on birth certificates. Consideration should also be given to the importance of reporting congenital malformations that are diagnosed later on in life.

PERSONNEL AND MANPOWER

The Committee gave consideration to problems existing in the area of staffing existing facilities and programs as well as those that might be needed in the future. The specific professional areas in which recommendations are made are: physicians, psychologists, nurses, social workers, teachers, speech pathologists, occupational therapists, physical therapists, medical and laboratory technicians. Specific questions pertaining to the above professions to which the Committee directed its attention were: What kinds of professional and non-professional training can be obtained in South Dakota at the present time? What additional types of training might be feasibly initiated in South Dakota? When personnel cannot be provided from within the state, where can it be obtained? What are and what will be the staffing needs in the future? How can adequate staffing be obtained for facilities located in low population areas of the State? Why do many people leave South Dakota for employment after receiving all or a part of their training in the State? How can more of these people be persuaded to remain in South Dakota? How might salary levels in South Dakota be increased to a base competitive with other states?

South Dakota maintains a two-year medical school at the University of South Dakota. Because of the caliber of training received there, no difficulty is experienced in obtaining placement for the students in other states for the completion of medical courses. It is the recommendation of the Committee that no attempt be made at this time to establish a four-year medical school. The number of medical students does not warrant the additional expense involved. No measurable benefits would accrue to the state by way of supply of physicians because no measurable problems are encountered in recruitment of physicians under the present system. There is a shortage of medical specialists in some fields, but South Dakota is not in a position to train any specialists.

Training for psychologists is provided at the University of South Dakota in undergraduate, master's and doctoral levels. The Ph.D. program is limited to comparative psychology and human factors. An approved (APA) program in clinical psychology would provide a source of staff for all of South Dakota from students involved and ultimately result in a savings to the state because of not then having to offer premium salaries to those coming from outside of the state. This would also tend to reduce the problems of staffing low population areas of the state which are usually only filled by persons knowing the area. **The State Department of Health or the Division of Pupil Personnel Services should seek out the possibility of obtaining a federal demonstration grant to employ a psychologist to accompany the mobile speech screening team now surveying the State.**

Nursing education programs are offered, three in baccalaureate, six diploma, and four licensed practical schools, but none are available at the graduate level. The baccalaureate and diploma classes are able to admit all the qualified applicants. The licensed practical nurse training units are not able to accept all of the applicants probably mostly due to the lack of clinical facilities. The major problem in the area of nursing education is in recruitment of faculty which is related to the fact that no graduate level training is available in South Dakota. The next problem is one which indicates a tremendous number of nurses leaving South Dakota. The factors influencing their leaving are most frequently those over which little or no control by direct state action can be helped. **Increases in the area can be made by the establishment of a master's degree program and by establishing a Public Health Training Center.**

The University of South Dakota and Augustana College both offer undergraduate study in social work, but no work may be taken in the state to receive approval as a graduate social worker. There are 70 graduate schools accredited by the Council on Social Work Education, six of which are the primary sources of employable social workers for South Dakota. These include: University of Denver, University of Iowa, University of Minnesota, University of Kansas, University of Nebraska, University of Washington, University of St. Louis, Missouri. Because of the lack of available supervised field instruction unit agencies needed for graduate work the University is not in a desirable position to easily work out such a problem. The only way it could be done is to work out block field placement with qualified agencies. The necessary agencies to use in connection with field instruction are available in Sioux Falls. Perhaps some arrangement could be made with Augustana College in support of a graduate school. Because of the extreme shortage of social case workers (five positions for every available employee) a number of agencies seeking to employ more personnel have developed a policy of recruiting social case service aids with the idea that training grants will be used to obtain the necessary degree training and return to the position after the completion of the professional training.

Special education teachers may receive certification required courses from the University of South Dakota and from Northern State College. Several other colleges offer one or more courses which have some of the content in the area of special education. **Other new schools need to be started at the present time to serve an anticipated need for more specialized teachers and to serve as a means of recruitment of more teachers into the field.** Some convenience by way of location might be experienced in the western part of the state, but the number of persons registering for special education does not justify more schools offering the courses. Some advantages would be gained by making courses available to teachers who are otherwise trained but wish to specialize in teaching handicapped children.

Speech pathologists have been receiving training at Northern State College, South Dakota State University and the University of South Dakota. None of these institutions offers a program which meets the new requirements of the American Speech and Hearing Association; however, the program at the University of South Dakota complies with the previous requirements for basic certification (not available after January 1965). **Further training should be initiated at the University of South Dakota by adding twelve to fifteen hours of course work.** To accomplish this it would be necessary to hire a staff member who holds a doctorate in speech pathology or audiology who could devote full time to teaching. Two area programs are in operation at the present time in South Dakota and the Division of Pupil Personnel Services has provided funds for surveying speech and hearing needs in the state, and one man is presently in the field testing hearing and screening speech problems. **Mobile units supplied by county or multiple county arrangement appear to offer the best possibility for answering the needs of speech services to all students** (including the retarded) for the sparcely populated areas of South Dakota. Providing trained persons is essential before such units can be staffed.

Occupational therapy training is not available in South Dakota. Neighboring states offering such training are North Dakota, Iowa, Kansas, Colorado, Minnesota and Wisconsin. Some of the courses needed for occupational therapy training are available at the University of South Dakota in connection with the Medical School, and some are available at South Dakota State University in connection with pharmacy and nurse training. Because of the difficulty in obtaining staff to train the small number of persons interested in occupational therapy, though the need for therapists is accute, it seems unlikely that any training can be offered in South Dakota in the near future. An arrangement for scholarships to individuals who will agree to return to the state seems more feasible at the present time.

Physical therapy training is not available in South Dakota. Much the same situation exists as far as the possibility for training is con-concerned as with occupational therapists. It is unlikely that training can be offered in the foreseeable future. Scholarships should be available to students wishing to return to South Dakota.

There are seven schools of medical technology in South Dakota which are approved by the Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of the American Society of Clinical Pathologists. They have a combined student capacity of forty-eight. These schools are affiliated with one or more educational institutions which provide the first three years of education and which grant the degree after the twelve-month period of hospital education and training is completed. Though there is a need for more medical technicians, the schools do not always reach their capacities. The major problem seems to be one of recruitment.

In most cases, laboratory technicians, medical and laboratory assistants, have no formal training beyond high school; but have trained on the job to perform simple laboratory procedures. Some have taken one-year courses in unapproved and commercially operated laboratory schools. A hospital school for Certified Laboratory Assistants has been established in Watertown during the time of the planning activity in South Dakota; but this Committee feels that more such facilities are needed in the State. This training program provides standardized training and national certification under medical auspices for Certified Laboratory Assistants. These schools could not be set up in the same hospitals which have approved programs for the training of medical technologists. Perhaps one or more of the **hospitals not offering a medical technologist training could be encouraged to initiate such a program and thereby provide a supply of persons better qualified to staff the laboratories of the smaller hospitals.**

Because of the difficulties experienced in recruitment of professional persons in many fields, **one method of obtaining persons** who have personal ties in South Dakota communities but lack the professional training **would be to bring the training to them through an arrangement with the extension divisions of one or more of the state supported schools.** In this way they could arrange to have experts come into one or two locations within the state, present the courses on week-ends and return to their regular positions and still offer the best possible training to those South Dakota persons who wish to upgrade their training and go into professions when they have completed the requirements.

To encourage persons with specific interests in staying in South Dakota but who find their special training not available within the state, it would be desirable for the state to consider the possibility of making scholarships available to those who would agree to return to South Dakota to work after completing their training. This would encourage South Dakota students to go into needed professions and offer a much better possibility of them returning after doing course work out of state. The scholarships could be granted by the state in an amount equal to the difference the student must pay in costs of tuition and transportation to the place he must go to seek the necessary course work as compared with the cost in a state supported South Dakota school. The system should not be contingent upon other scholarships the individual may be able to obtain from other sources. **It would be more economical for South Dakota to make an arrangement of this type than it would be to attempt to offer complete course work in each specialty** such as physical, occupational therapy, or perhaps social work. When the cost of the extra tuition costs begins to reach the point of the cost of providing the courses in South Dakota it could be discontinued. **In order to economically use the available staff, most South Dakota communities should think in terms of mobile or shared services in speech therapy, and psychology.**

PREVENTION

The prevention of mental retardation is presently the only effective remedy in reducing mental retardation in the general population. Any person having mental retardation cannot be restored to a normal level of intelligence, leaving special education and training as the only effective means to alleviate the effects of lost intelligence. Therefore, in future planning for mental retardation, **prevention should retain a high priority for action.**

Over 120 well defined diseases and syndromes are presently known to be associated with mental retardation, but these account for only one-third of the mental retardation diagnosed. The other two-thirds are called "undifferentiated", meaning no cause is known. In a few of the known causes mental retardation can be prevented if the disease is recognized early and treated appropriately. In most of them, such as Down's syndrome (mongolism) or other chromosomal aberrations, even if diagnosed immediately after birth, no treatment is available at this time.

There are, however, a number of postnatal factors which cause mental retardation which can be prevented.[1]

Classification of causes by time of onset which cause mental retardation are given in the following listing.

A. Prenatal factors
   1. Hereditary factors, including inborn errors of metabolism.[2]
   2. Chromosomal abnormalities.
   3. Transplacental infections.
   4. Maternal irradiation.
   5. Developmental abnormalities of the central nervous system.

B. Perinatal factors
   1. Low birth-weight, multiparity, neonatal care, delivery.
   2. Anoxia.
   3. Birth injury.
   4. Vascular accident.
   5. Encephalopathy associated with kernicterus.

C. Postnatal factors
   1. Central nervous system infections.

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[1] Examples of these factors are measles encephalitis and lead encephalitis.
[2] Some of the inborn errors of metabolism are PKU, cretinism, and galactosemia.

2. Cerebral trauma.
3. Cerebral vascular accidents.
4. Convulsive disorders.
5. Poisoning (general, lead, vitamin D, etc.)
6. Miscellaneous.

Because of the possibilities of hereditary factors entering into an unidentified percentage of cases of mental retardation, it is recommended that persons in families where there is a history of mental retardation or other birth abnormalities should voluntarily seek physical examinations and medical consultation to determine if further studies are necessary. Chromosomal studies may be needed in a number of families in order to identify potential transmission of handicapping conditions such as mongolism. Chromosomal studies of this type are currently being conducted at Sioux Valley Hospital in Sioux Falls and the University of South Dakota, Vermillion. More research into the suspected genetic factors of production of mental retardation may bear out the necessity of more investigation of potential parents in the future.

Hereditary diseases are more frequent in the offspring of marriages between relatives. First cousins, for example, have half of their genetic material from the same pair of grandparents, increasing the opportunity of pairing of detrimental genes tremendously. The possibility of hereditary problems in the marriage of second cousins needs further investigation. These and other problems affecting marriage laws should be reviewed under the auspices of the Institute for Uniform Law, Chicago, Illinois.

The need for usable statistical material in the field of mental retardation and the necessity to have a "clearing house" for specific questions in this field, as an example, the availability of certain tests, their usability and significance—emphasizes the problem of a central institute or agency inside of the State to coordinate the medical factors involved in mental retardation. This problem is discussed in the section of this plan dealing with research and statistics.

It is recommended that a Committee be established on a regional basis to evaluate new information and changing views in mental retardation relating to diagnosis, treatment, and prevention (such things as radiation control) and to distribute their findings to professional persons.

It is recommended that the South Dakota Hospital Association and the South Dakota State Medical Association investigate the feasibility of premature centers, maternal and children centers, and exchange transfusion centers throughout the State.

It is recommended that the South Dakota State Medical Association give consideration to improvements in regulations regarding the reporting of communicable diseases (such as encephalitis).

It is recommended that a committee (under the extended planning program) **continue to study and distribute information concerning mental retardation caused by poisonings** (such as lead, arsenic, mercury, kerosene, oils, glues, and vitamins).

APPENDIX

COUNTY QUESTIONNAIRE

*1. OCCUPATION ....

*2. COUNTY ....

*3. ARE YOU BEING INTERVIEWED THROUGH PERSONAL CONTACT BY INTERVIEWER? YES.......... NO..........

*4. IF ANSWER TO QUESTION 3 IS "NO", HOW DID YOU RECEIVE THIS QUESTIONNAIRE? ....

*5. IS THERE SOME ONE PERSON(S) OR AGENCY KNOWN IN YOUR COMMUNITY AS A SOURCE OF INFORMATION AND RESOURCE FOR REFERRAL ON PROBLEMS OF MENTAL RETARDATION?
IF YES, IDENTIFY:.............................. YES.......... NO..........

* * * * * * * *

*1. ARE YOU A MEMBER OF THE ASSOCIATION FOR RETARDED CHILDREN? YES.......... NO..........

*2. ARE YOU THE PARENT OF A RETARDED PERSON?
YES.......... NO..........

*3. IS YOUR AREA SERVED BY A CHAPTER OF THE ASSOCIATION FOR RETARDED CHILDREN? YES.......... NO..........
IF YES, WHICH ONE? ....

*4. IS THE PRESENT ASSOCIATION MEETING THE NEEDS OF ITS AREA? YES.......... NO..........
a. If not, in what ways is it not adequately serving? ....

*5. SHOULD A NEW AREA BE DESIGNATED FOR THE A.R.C.?
YES.......... NO..........
a. If yes, what area(s) should be changed, how and on what basis? ....

I. EDUCATION:

*1. Within your county, are there special classes available through the public school systems for retarded children of school age? YES.......... NO..........

*2. What are the age limits for which appropriate schooling is available? LOWER LIMIT.......... UPPER LIMIT..........

*3. How many children are served in the Special Education classrooms in your County? TOTAL..........

*4. How many retarded children in your County are known **not** to have special education facilities available to them?
TOTAL..................

5. Are the children who properly should be placed in Special Education rooms **not so** placed because parents will **not** use the facilities? OFTEN .... SOMETIMES ....
SELDOM .... NEVER ....

6. Have any schools in your County used the services of State agencies to obtain psychological evaluation of students? YES .... NO..........
(a) If Yes, please indicate which state agencies used and the number of students evaluated: ....

7. Please give the location of the Special Education Classrooms in your County: ....

8. Special Education classrooms are designed to serve different age groups, i.e. (1) Pre-school; (2) Primary; (3) Intermediate; (4) High School; (5) Pre-vocational. They are also classified to provide: (A) Life skills training; (B) Academic emphasis; (C) Multi-purpose. Please indicate the age and type of training each classroom serves. Use the back side of this page if more space is needed.
LOCATION.............................. AGE LEVEL..................
TYPE OF SERVICE..........................

*9. Are education programs available for the adult mentally retarded? YES.......... NO ....

*10. In your opinion, are the existing classrooms in your County adequate to give services to the retarded? YES.......... NO..........

*11. Do you feel that more classrooms are needed in your County? YES .... NO ....

*12. Are these special classrooms available to children living outside of the school district in which the classrooms are located? YES .... NO ....

13. What is the greatest distance that any retarded child must travel in order to attend the special class to which he has been assigned? MILES..............................

(A) What method of transportation is provided?

(a) Parent's car
(b) Other private auto
(c) Bus
(d) Bicycle
(e) Walking
(f) Horseback
(g) Other

14. In your county, is there any situation in which more than one school district has joined with another for the purpose of setting up a special classroom and providing a teacher?
YES........ NO ....
(A) If yes, please give details as to location and arrangements of the districts: ....

15. Are the teachers who are teaching the special education classes in your county certified by the State Department of Public Instruction, Division of Special Education, as qualified special education teachers? YES........ NO .... Number Certified........
Number Not Certified ....

16. Are there any special education facilities available in your county which are unable to open because of a lack of qualified teachers? YES........ NO........
(A) If Yes, please give location of these facilities:........................

17. Are there any other types of handicapped children included in the special education classrooms for the mentally retarded?
YES........ NO........
(A) If Yes, please give nature of disability.

(a) Emotionally disturbed
(b) Deaf
(c) Blind
(d) Physically handicapped
(e) Other ....

*18. How many children who are probably retarded are attending regular classrooms which are **not** designed for retarded children? EST. NUMBER........................

19. Are there provisions made for the transfer of children from special education classrooms to vocational placement?
YES........ NO ....
(A) If Yes, please check the provisions being made:

(a) School work programs
(b) Sheltered workshops
(c) Sheltered work projects
(d) On-the-job training programs
(e) Vocational training programs
(f) Other ....

*20. Are the facilities for the retarded of comparable quality to other education facilities? YES .... NO........

*21. Are there any facilities available in your county for day care of the retarded? YES............ NO............

(A) If yes, please check the available facilities in relation to the age that each facility serves:

AGE 0-6	AGE 7-14	AGE 15-19
Staffed day care............	Staffed day care............	Staffed day care............
Staffed activity center............	Staffed activity center............	Staffed activity center............
Foster care	Foster care	Foster care ....
Other............	Other............	Other............ ....

AGE 20-24	AGE 35 & OVER
Staffed day care............	Staffed day care............
Staffed activity center............	Staffed activity center............
Foster care	Foster care ....
Other............	Other............ ....

*22. Please check the professional persons who are available in your county to counsel parents of a mentally retarded child:

(a) School superintendent
(b) School principal
(c) Clergyman
(d) Psychiatrist
(e) Pediatrician
(f) General medical doctor
(g) Guidance counselor
(h) School Psychologist
(i) School social worker
(j) Private agency
(k) Public Health Nurse
(l) Genetic Counselor
(m) Other ....

*23. Please check any other special education needs which are present in your county:

(a) Speech therapy
(b) Parent education
(c) Financial Assistance
(d) Pre-school training
(e) Religious training
(f) Counseling
(g) Other ....

*24. Please make any remarks you might have concerning "Education" for retarded persons:

II. VOCATIONAL REHABILITATION, OCCUPATION, EMPLOYMENT, AND OTHER SERVICES:

*1. In your county how many retarded persons are working in salaried jobs? EST. NUMBER........................

(A) How many are family employed? EST. NUMBER........................

(B) Please check the type of work as separated by age range:

BELOW AGE 25		25 & OVER	
Farm labor	....	Farm labor	....
Day Labor	....	Day Labor	....
Custodial service occupations	....	Custodial service occupations	....
Semi-skilled	....	Semi-skilled	....
Other..........................	....	Other..........................	....

*2. What occupational opportunities exist in the community?..........

3. What opportunities for sheltered or protected employment exist? ....

4. What facilities for vocational training, including social and personal management, exist? ....

*5. Are the job opportunities for the handicapped adequately publicized? YES.......... NO..........

6. Are the follow-up counseling services available to assist the retarded person after he has obtained employment? YES.......... NO..........

(A) If Yes, please check the agencies responsible for this counseling service:

(a) Vocational Rehabilitation
(b) Welfare Department
(c) Department of Health (Public Health Nurse)
(d) School systems
(e) Other ....

*7. Should this county join with others to provide training or sheltered employment for the retarded? YES .... NO ....

(A) If Yes, how would you suggest this might be accomplished?

(B) If No, why not? ....

8. What diagnostic facilities in your county are equipped to serve retarded persons? ....

(A) Where do persons usually go for diagnostic services?

*9. Would you please number (IN ORDER OF PRIORITY) the community services you would like to see developed more extensively for the **identification** of persons with mental retardation.

(a) Diagnostic medical services
(b) Diagnostic laboratory services
(c) Public Health services
(d) Well baby clinic
(e) Well child clinic
(f) Social services
(g) Psychological services
(h) Other ....

*10. Please number (IN ORDER OF PRIORITY) the community resources you would like to see developed more extensively in order to improve the **treatment** of persons with mental retardation:

(a) Family and children service agencies
(b) Foster homes
(c) Special education facilities for academic education, as:
  part of public school
  separate facility
(d) Special education facilities for life skills training, as:
  part of public school
  separate facility
(e) Sheltered workshops
(f) Day care
(g) Family counseling and assistance
(h) Public education
(i) Training of personnel
(j) Recreational opportunities
(k) Programs for long term supervision and guidance
(l) Vocational rehabilitation
(m) Home training
(n) Other ....

*11. Referring to Questions 9 and 10, in what ways might the needs best be met? (Please number in order of priority)

(a) By community action through cooperation and association between private and public groups.
(b) By county action through cooperation and association between private and public groups.
(c) By state action through cooperation and association between private and public groups.
(d) By Federal aid through direct grants to NEW facilities.
(e) By Federal aid through direct grants to existing facilities.
(f) By Federal aid through grants for study and research.
(g) By state aid through grants for study and research.
(h) Other ....

III. RECREATION AND RELIGION:

*1. Do retarded persons participate in regular recreational programs in which non-handicapped persons regularly participate? YES .... NO .... SOMETIMES ....

(A) If Yes, please check the programs in which the retarded are participating:

(a) Scout programs
(b) 4-H programs
(c) F. F. A.
(d) F. H. A.
(e) Boys Clubs
(f) City recreational programs
(g) Other ....

2. Are SPECIAL programs for the retarded provided in any of these organizations?

(a) Scout programs
(b) 4-H programs
(c) F. F. A.
(d) F. H. A.
(e) Boys Clubs
(f) City recreational programs
(g) Other ....

*3. In what ways could the recreation programs be improved? (Please number IN ORDER OF PRIORITY)

(a) Provision of better trained staff
(b) Facilities for recreation located closer to the consumer
(c) Development of special programs designed for the retarded only.
(d) Other ....

*4. What special provisions are made for the religious training of the retarded in your county?

(a) Special church school classes
(b) Special religious services
(c) Provisions for the young person to attend regular young people's clubs
(d) Other ....

5. List the churches in your county, with the number of retarded served, that have special classes for the retarded. ....

6. List the churches in your county, with the number of retarded served, which accept the retarded in regular classes. ....

7. Please number the other services (IN ORDER OF PRIORITY) that the clergy and church workers provide for the retarded in your county:

(a) Counseling to parents ....
(b) Counseling to the retarded person ....
(c) Referral to medical persons ....
(d) Referral to Welfare ....
(e) Referral to Public Health Dept. ....
(f) Referral to psychologist or guidance persons ....
(g) Referral to psychiatrists ....
(h) Referral to State Hospital & School ....
(i) Referral to S. D. Association for Retarded Children ....
(j) Referral to Special Education ....
(k) Other ....

IV. LEGAL

*1 Please number in order of priority the problems which may require attention by the legal profession, that you feel exist in your county (or statewide) which affect the adequate handling of the mentally retarded.

- (a) Adjudication ....
- (b) Committment Process ....
- (c) Admission to Institutions ....
- (d) Criminal rights ....
- (e) Civil Rights
    - 1. Contracting ....
    - 2. Marriage ....
    - 3. O.A.S.I. Benefits ....
    - 4. Property ownership ....
    - 5. Sterilization ....
- (f) Registration of Retarded ....
- (g) Drug Control in relation to pregnancy ....
- (h) Eligibility for vocational education ....
- (i.) Eligibility for enrollment in special education classes ....
- (j) Licensing and inspection of non-public facilities ....
- (k) Other ....

V. PUBLIC AWARENESS

*1. Please number, IN ORDER OF PRIORITY, the major problems your region has in relation to public awareness of the mental retardation problem.

- (a) Confusion between mental retardation and mental illness ....
- (b) Lack of knowledge of the scope of the problem ....
- (c) The number affected by retardation ....
- (d) Lack of understanding that many retarded children can be helped by special education facilities ....
- (e) Lack of understanding that the retarded can be helped by workshop programs ....
- (f) Lack of understanding of the employability of the retarded ....

(g) Lack of understanding that provisions can be made for the retarded other than institutionalization ....
(h) Parental misunderstanding and guilt in having a retarded child ....
(i) Lack of special education knowledge on the part of school personnel
(k) Other ....

*2. Please check any of the following whose attitude is often a problem:

(a) Young adults
(b) Persons who have no handicapped people in their homes
(c) Administrators
(d) Legislators
(e) County Commissioners
(f) Employers
(g) School age children
(h) Social workers
(i) Psychologists
(j) Medical doctors
(k) Pediatricians
(l) Psychiatrists
(m) Nurses
(n) Teachers
(o) Other ....

*3. Please describe below what plans (if any) are now being made for modifying, expanding, or curtailing present services to the mentally retarded in your county. ....

GLOSSARY

A.A.M.D.: American Association on Mental Deficiency.

Academically Orineted Child: The retarded child who is able to learn subjects of an academic nature; i.e. reading, arithmetic, history, etc.; usually falling within the I.Q. range of 50 or above.

Adjudication: Determined by the court to be mentally deficient.

A.R.C.: Association for Retarded Children.

Chromosomal Aberrations: Deviations from the normal structure of chromosomes (microscopic bodies which carry the genes or hereditary characteristics within living things) within the body.

Commitment Process: The process whereby a County Sub-Commission, made up of the County Judge, the States Attorney, a County Welfare Representative, a physician, and the County Superintendent of Schools, determines whether or not a person should be committed to the State Commission for the Mentally Retarded and/or the State Institution for the mentally retarded.

Cytogenetics Laboratory: A laboratory facility which studies the structural basis of heredity and variation; could be used for chromosome analysis to diagnose specific conditions in mental retardation.

Day Care: Care and training given to the mentally retarded in a group setting during some part of the day (less than 24 hours) by specially trained staff.

Diagnostic Facility: A facility housing coordinated medical, psychological and social services, supplemented where appropriate by nursing, educational, or vocational services to diagnose and evaluate, determine the needs of, develop and reassess a specific plan for the mentally retarded individual.

Family Counseling: Advice, information, and guidance given by professional individuals to the parents and family where mental retardation exists.

Foster Care: Care given outside the home for part of a day, for a group of not more than six children.

Genetics: The branch of biology dealing with heredity and variation among related organisms, largely in their evolutionary aspects.

Geriatrics: The subdivision of medicine which is concerned with old age.

Habilitation: The training of an individual for employment when there is no previous work experience or knowledge present.

Inborn Errors of Metabolism: Abnormalities occuring during the development and present at birth in the continuous processes in living organisms, such as the process of building food into protoplasm, release of energy for all vital functions, etc.

Life Skills Oriented Child: The retarded child who is able to learn very little of an academic nature, but can learn self-care, social skills, etc; usually falling with in the I.Q. range below 50.

Mental Competency: Mentally capable of being independent.

Mental Illness: A disorder of the personality or the emotions.

Mental Retardation: Refers to sub-average general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

Opthamologist: A physician specializing in the study and treatment of defects and diseases of the eye.

Orthopedically Handicapped: Handicapped by a deformity, disease, or injury to the bones, joints, etc.

Publication: As used in this text: "Publication of names of those adjudged to be mentally retarded". The specific intent of the term as used within the law has not been legally defined.

Public Law 89-97: The law passed by Congress in 1965 to authorize funds for the states to continue mental retardation planning and implementation until June 30, 1968.

Rehabilitation: The retraining of an individual for employment when there has been previous work experience or knowledge present.

Sheltered Workshop (Adjustment Training Center): Services involving a program of paid work which provides (1) work evaluation; (2) work adjustment training; (3) occupational training; and (4) transitional or extended employment; and which is carried out under the supervision of personnel qualified to direct these activities.

State Commission for the Mentally Retarded: A Commission established by the South Dakota Legislature in 1951 to provide for the protection, care, and training of all mentally retarded who are residents of the State of South Dakota. The Superintendent of the Redfield State Hospital and School is chairman of this Commission.

Urinary Tract Infections: Infections within the system of organs within the body having to do with production and secretion of urine.

COORDINATING COMMITTEE:

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6 MILLION MENTALLY RETARDED HAVE ENOUGH PROBLEMS WITHOUT YOU ADDING TO THEM.

NOW, YOU'RE PROBABLY SAYING TO YOURSELF, WHY BLAME ME? I DIDN'T DO ANYTHING."

THAT'S THE PROBLEM!!

Do Something . . .

1. Encourage your schools to have special teachers and special classes to identify and help mentally retarded children early in their lives.
2. Urge your community to set up workshops to train retardates who are capable of employment.
3. Persuade employers to hire the mentally retarded and help those who cannot find work by themselves.
4. Accept the mentally retarded as fellow human beings who can become assets to their families and communities, rather than burdens on society.
5. Write for the free booklet from the President's Committee on Mental Retardation, Washington, D.C.

MENTAL RETARDATION PLANNING STAFF:

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Health Program Representative 8-4-64 to 12-31-65	Thomas E. Scheinost, B.A. State Department of Health Pierre, South Dakota

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Michelle Ottum; Stenographer; 1-6-65 to 2-5-65

Lois Heinzen; Typist Clerk; 6-3-65 to 8-31-65

Nancy Fenley; Stenographer; 2-19-65 to 12-31-65

Linda Beaner; Typist Clerk; 11-12-65 to 12-31-65

Betty Sterner; Typist Clerk; Redfield; 6-8-65 to 8-13-65

Lee Pfeiffer; Chief Clerk—Sioux Falls; 7-1-64 to 12-31-65